

*Transsexual Women on the Journey of Sexual Re-alignment in a Hetero-normative
Healthcare System in the Western Cape*

By

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Declaration

I, Douglas David-John Newman-Valentine, declare that “*Transsexual Women on the Journey of Sexual Re-alignment in a Hetero-normative Healthcare System in the Western Cape*” is a product of my own original work unless otherwise stated, and that all sources that I have used or quoted have been indicated and acknowledged by means of complete and accurate referencing. I also declare that this research has not been submitted to any other university.

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Abstract

Transsexual women who embark on the journey of sexual realignment in pursuit of achieving synergy between their gender identity and physical embodiment may experience side-effects directly related to their treatment. Even though access to sexual realignment treatment for transsexual women is liberating, these side-effects may impact negatively on their physical and psychological health. Women are forced to seek care for their sexual realignment services and side-effects of treatment in a hetero-normative healthcare system which seems to be unprepared for and even hostile towards the needs of this marginalised community.

The purpose of this study was to understand the life-world of transsexual women in relation to their awareness of their unique health needs as a direct result of sexual realignment treatment, and their health-seeking behaviours, practices and experiences of responses in negotiating health care for their transgender-related health needs in the healthcare system. The overarching question asked in this research was: What are the lived experiences, and meaning of these experiences, for transsexual women during the sexual-realignment process when negotiating health care for their transgender-related healthcare needs in the healthcare system?

Participants in this study were selected through purposive and snowball sampling. In-depth interviews were conducted with ten participants selected from urban, peri-urban, and rural areas of the Western Cape. Theoretical saturation was reached with the tenth participant, and further selection of participants was ceased.

The data was viewed through a trans-inclusive feminist lens with a concurrent collection and analysis process as guided by the steps of analysis of Interpretative Phenomenological Analysis (IPA), as developed by Smith (2010). IPA is a modern qualitative approach to research inquiry which harnesses the strengths of phenomenology, hermeneutics, and ideography.

The analysed data were illustrated in a master theme graphic which contained one superordinate theme, two subordinate themes and various categories. The superordinate theme of this study was named "Towards organic Womanhood", while the two subordinate themes were coined "Embracing Womanhood", and "Facing the Giant in order to Become". The subordinate theme Embracing Womanhood gives insight into aspects of transsexual women's journey of moving towards a state of organic womanhood, whereas the subordinate theme Facing the Giant in order to Become maps out powers in the healthcare system which prevent transsexual women from having a smooth transition journey.

This study illustrates that transsexual women have a need to align their bodies with their gender identities, but even though South Africa has legislation which protects the health and rights of transsexual women, transsexual women find it challenging to make the transition. Health practitioners are ill-equipped to manage transsexual women, the care which they receive in the government-funded healthcare system is of a poor standard, and they are

subjected to extremely long waiting periods to have access to surgical sexual realignment services.

Recommendations are made for the healthcare system, policy makers and educational institutions in order to stimulate the South African healthcare system to become inclusive and affirming to the needs of transsexual women. Furthermore, recommendations for researchers are made to stimulate the debate around transsexual health care in the scientific literature.

Dedication

I dedicate this thesis to the two most inspirational people in my life: my late maternal grandmother, Magdalene Jones, and my late father, Douglas Newman.

My grandmother never had the opportunity to become educated, but through her hard work she laid the foundation to fulfil her vision of having educated children. My father played a fundamental role in my life through being a public advocate for the rights of the LGBTI community, even when he himself was ostracised by his family for believing that LGBTI rights are equal to human rights.

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On my own, I would have never been able to complete this thesis. Therefore I wish to acknowledge the following people who formed part of my support network while undertaking this study:

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It was during this time of intensive study that I realised how much support, love and care I receive from friends, family and the various communities in which I venture. It would be impossible to acknowledge every person who provided me with support on my journey. However, I need to acknowledge the three most important people in my life:

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- My daughter, Rebecca Newman-Valentine, who in her innocence always smiled and understood that Pappa has to “work” all the time and attend “meetings”

- My husband, spouse, lover, friend, and confidant Marlow Newman-Valentine. I have no words to ever thank you for your support on my journey. You allowed me to become fully immersed into the life-world of transsexual women, and never once complained about being the full-time operations manager of our family unit. You have showed me the meaning of true love.

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Chapter 1 Background to the study

1.1 Introduction

1.1.1 Framing the T in LGBTI

Transsexual women are grouped under the umbrella term lesbian, gay, bisexual, transgender and intersex (LGBTI), which is used to describe people who do not identify as the heterosexual norm (which society perceives as the norm). This umbrella term in itself is not very accurate to describe this subset of the population. The L (lesbian), G (gay), and B (bisexual) of LGBTI describes the sexual orientation of people, whereas the I (intersex) is an anatomical description of people with ambiguous genitalia, and the T (transgender) describes people with a gender identity incongruent with their physical embodiment.

The T in LGBTI is used to include transgender people. This category of described people consists of a heterogeneous group with various descriptions, but for the purpose of this study the terms transgender and transsexual will be differentiated.

The term transgender is used as an all-inclusive politically correct term to describe people who venture into the opposite gender of that which they have been assigned at birth. Strictly this does not mean that a transgender person will “live” permanently in the opposite sex, or will seek medical help to permanently change their physical bodies to fit their gender identity, but they could be described as “gender benders”.

A transsexual person, on the other hand, is someone who has a gender identity in opposition to that of their assigned sex at birth, and they wish to realign their physical embodiment to their gender identity. There can either be a transsexual man or female-to male (FTM) transsexual or a transsexual woman or male-to-female (MTF) transsexual.

This study places focus on transsexual women who are on the journey of sexual realignment while utilising the hetero-normative South African healthcare system. Throughout this report an MTF transsexual woman will be referred to either as a transsexual woman, or a woman.

1.1.2 Gender realignment

Gender realignment is an option for transsexual women to realign their physical embodiment with their gender identity. This process consists of using life-long feminising hormones and surgical sexual realignment. Ideally, transsexual women will have the option of designing their transition together with the multidisciplinary health team, which could include various surgeries and hormones or aspects thereof.

Gender realignment is seen as liberating, as it creates a synergy between the gender identity and physical embodiment of women. However, this process also appears to have side-effects on the physical and mental health of transsexual women.

Hormonal treatment may result in transsexual women experiencing an increase in their diastolic and systolic blood pressure, developing diabetes, pulmonary embolism, deep

venous thrombosis and osteoporosis (Elbers et al., 2003). They also have a higher incidence of certain cancers when they are on hormone treatment (Persson, 2009).

As with all surgical interventions there are risks of postoperative infection with the surgical parts of the sexual realignment process. There is also the risk of developing recto-vaginal fistulas with the construction of the neo-vagina. The tissue in the neo-vagina itself will also make transsexual women anatomically vulnerable to the human immunodeficiency virus (HIV).

Apart from the physical side-effects which transsexual women may suffer due to their realignment process, there are also strong links between depression and suicide and the use of feminising hormones (Wassersug & Gray, 2011).

1.1.3 Finding assistance with sexual realignment

The process of sexual realignment forces transsexual women to have a close relationship with the healthcare system and the healthcare providers within the system. The multidisciplinary healthcare team is involved in the initial assessment and planning of the realignment journey of transsexual women. Furthermore, the women have to be closely monitored by healthcare providers while they are taking feminising hormones. Peri-operative care is also needed, and they will have to enter the healthcare system for management of side-effects and complications should they arise at any stage. Throughout the process transsexual women need support from mental healthcare providers to maintain their mental health.

Finding this essential care is not always easy for transsexual women, for various reasons. Being part of a very small population, healthcare systems around the world do not see the healthcare needs of transsexual women as a priority. Access to private healthcare systems is also difficult for transsexual women, as most medical insurance companies do not view care and treatment related to gender realignment as essential, but rather as cosmetic treatment and thus do not pay for such support. Finding care for transsexual women is also related to the politics of the country in which they find themselves.

1.1.4 Politics and care

Besides the fact that the healthcare system does not see the healthcare needs of transsexual women as a priority, legislation also has an impact on the care which transsexual women receive. On the African continent, most of its countries have conservative legislation whereby any sexuality besides heterosexuality is illegal and even punishable.

Having such legislation in a country will prevent the healthcare system from providing care and treatment to transsexual women, as the existence of transgenderism is not accepted.

South Africa has always been different to other African countries with regard to the treatment of transsexual women. Prior to liberation in 1994, sexual realignment support services were offered to select transsexual women, even under a conservative government. Post-liberation, South Africa is governed by a progressive Constitution protecting the rights of transsexual women. Even though they are explicitly protected in the Constitution, the Healthcare Act is silent with regard to the protection and care of transsexual women, with the result that no

focus is placed on their health needs. Later in this report I will elaborate on the pre- and post-liberation political context of South Africa and their influence on the provision of supportive care for transsexual women.

1.1.5 Framing the context of the study

South Africa is the most southern country on the African continent and is made up of nine provinces. The study was conducted in the Western Cape Province in 2013 and 2014. The Western Cape makes up roughly 10% of South Africa and has a land area of 129 462 square kilometres. It has been described as the province with the best functioning healthcare system in the country. It has three tertiary hospitals, ten district hospitals and numerous community health centres and clinics. This publicly funded healthcare system functions alongside a network of private hospitals and clinics to serve a population of 5 822 734 people (Western Cape Government, n.d.; Statistics South Africa, n.d.).

The province consists of a large urban metropolitan area, peri-urban areas, and rural areas. Generally the population has access to a clinic or district hospital, and would have to travel to the metro area to have access to one of the tertiary hospitals. Private hospitals and private healthcare practitioners practice throughout the province, mostly serving people who have medical insurance.

In the entire country there are only two clinics providing dedicated care to transsexual women who are in the process of sexual realignment. One clinic is in the Gauteng Province and the other is located in one of the tertiary hospitals in the metro of the Western Cape Province.

The “trans clinic” in the Western Cape supports transsexual women on their journey of sexual realignment, with assessment, endocrine services and surgical sexual realignment services. The hospital in which the clinic is located makes provision for four theatre cases per year for sexual realignment surgery. Some private practitioners and surgeons assist transsexual women on a fee-for-service basis because they are not supported by the medical insurance companies (Bateman, 2011).

Transsexual women in the Western Cape have one of two options. They could make use of the private healthcare system in order to assist them on their journey of sexual realignment. However, this option is financially out of reach for the average South African person, as the average household income is R143 461, as measured in 2011 (Statistics South Africa, n.d.).

The other option would be to make use of the “trans clinic” located in one of the tertiary hospitals of the Western Cape, but this would require them to reside in and around the city, and would make this limited service inaccessible to most transsexual women who live in the rural parts of the province.

1.2 Problem statement

The current treatment regimen of life-long hormonal treatment and surgical sexual realignment available to align the physical embodiment of transsexual women with their

gender identity is in itself empowering. This assists the woman to become a woman in the true sense. It greatly impacts their emotional well-being, since there would be no longer a need to constantly explain to intimate partners, family members, employers and the broader public why they are different to other people. However, transsexual women are vulnerable to the development of negative and unwanted side-effects of the treatment regimen.

Transsexual women are obliged to negotiate the public healthcare system for their trans-related health care. If and when they do this, their health problems are either missed or misdiagnosed. Poor health outcomes ensue, that eventually negatively impact on the morbidity and mortality statistics of women.

While there is evidence that transsexual women welcome their new embodiment, there is little evidence of their knowledge of the possible “complications” and how to seek appropriate health care. It is also not clear how emancipated they are to educate others with regard to their health needs, and to demand the health care that they deserve for their trans-related health care.

1.3 Purpose of the study

The purpose of this study is to understand the life-world of transsexual women in relation to their:

1. Awareness of their unique health needs as transsexual women that occur as a direct result of sexual realignment treatment.
2. Health-seeking behaviours, practices and experiences of responses in negotiating health care for their transgender-related health needs in the hetero-normative healthcare system.

1.4 Research question

What are the lived experiences, and meaning of these experiences, for transsexual women during the sexual-realignment process when negotiating health care for their transgender-related healthcare needs in the healthcare system?

1.4.1 Sub-questions

1. How do transsexual women experience and identify health problems related to their sexual realignment therapy?
2. What are their experiences of responses from health professionals when negotiating health care for their transgender-related healthcare needs in the healthcare system?

1.5 Study objectives

1. To explore, describe, and analyse how transgender women self-identify, describe and report their sexual realignment-related health problems.

2. To explore, describe, and analyse the current health-seeking behaviours and experiences of transsexual women in negotiating health care for their transgender-related health needs.
3. To explore, describe, and analyse the meaning transsexual women attach to their experiences of responses they receive from health professionals when negotiating health care in the healthcare system.

1.6 Assumptions

- The gender realignment process is not finite. When a transsexual woman embarks on the process of gender realignment she enters a continuum which will last until the end of her life.
- The legislative processes of South Africa do not protect the health and rights of transsexual women.
- The current healthcare system is not ready to provide a holistic healthcare service to transsexual women seeking care for their gender realignment treatment.
- Transsexual women are uninformed with regard to their own health and therefore do not have enough knowledge to claim the health care which they deserve within the healthcare system.
- Transsexual women are a marginalised people.

1.7 Terminology

Transgender

Transgender describes a person who ventures into the gender opposite to the sex and associated gender to which he/she was classified as at birth. This is a universally accepted umbrella term, including people on a continuum from “gender bending” to people who change their physical bodies to align them to their gender identity (Davidson, 2007).

Transsexual

A transsexual person is someone who has a gender identity in opposition to the assigned birth sex. This person will live in the opposite gender and wish to have his/her physical body changed to match their inner gender identity (Chase & Ressler, 2009).

LGBTI

Lesbian, Gay, Bi-sexual, Transgender/Transsexual, Intersex.

Sexual realignment

Sexual realignment is the medical and surgical process whereby the physical body of a person is changed to match their gender identity through the use of feminising hormones and gender-confirming surgeries.

Trans-phobia

Trans-phobia is the disgust, hatred, fear and violence directed towards a person who displays a gender identity in opposition to their assigned birth sex (Mizock & Mueser, 2014).

Neo-vagina

A neo-vagina is a constructed organ in transsexual women which resembles the look and feel of a vagina of a born woman.

Feminising Hormones

Feminising hormones are hormones which are administered to transsexual women in order to develop female secondary sexual characteristics in a male body.

Gender Identity

Gender Identity is the subjective experience of the person's own inner gender. The gender identity of a person could be either male, female or gender neutral.

Pansexual

A person can be described as being pansexual when he/she is attracted to another person irrespective of their gender identity or sexuality (Galupo et al., 2014).

1.8 The voice used in this report

In this study, myself as the researcher was the primary research instrument. This thesis is presented in the first voice. It is recommended to use the first voice while reporting on qualitative research in order to highlight the interpretation of the voice of the participant and to strengthen the interconnectedness between the researcher and the research (Given, 2008).

1.9 Organisation of the research report

This research report consists of nine chapters and has been structured in the following manner:

Chapter 1: Introduction

This chapter introduces the reader to the concept of "transsexual woman" and how she is placed within the broad term LGBTI which is often used to describe people who form part of a sexual minority grouping. The background to this study is clearly described together with the research question and the objectives. This chapter concludes with definitions of the terminology used in this report.

Chapter 2: Theoretical Framework

The reader will be introduced to the lens through which I viewed this research. I have introduced myself as the research instrument in this section in pursuit of clarifying any bias which I may hold.

Chapter 3: Aspects of Literature Review

In this chapter I discuss the literature which supports this study. I also validate through literature why the use of IPA as a method of inquiry is most appropriate to investigate the journey of sexual realignment of transsexual women in the Western Cape healthcare system.

Chapter 4: Methodology

IPA was used as a method of inquiry in this research. This chapter clearly presents the steps in research which were followed in conducting this study.

Chapter 5: Data Analysis

This chapter of the thesis demonstrates to the reader exactly how the steps in analysis for IPA were followed in order to interpret the data which were collected through in-depth interviews. I also explain how I utilised the strengths of both manual and electronic data analysis techniques.

Chapter 6: Findings

In this chapter the findings of this research are presented in a manner which will allow the reader to become engaged with the phenomenon under investigation. I have placed an emphasis on the voices of the participants in this study to demonstrate how I developed the master theme graphic which I present in this section.

Chapter 7: Discussion

The findings of this research are discussed with incorporation of relevant literature which either supports or challenge the findings.

Chapter 8: Recommendations and Limitations

In this section of the report I make appropriate recommendations grounded in the findings of this research. Furthermore, I acknowledge limitations to this study which I identified.

Chapter 9: Evaluating the Quality of this Research

Rigour is an important aspect of qualitative research and should be evaluated. In the final chapter of this report I evaluate the rigour of this study by using an accepted framework to evaluate the quality of qualitative research.

1.10 Conclusion

The umbrella term LGBTI is often used to describe all people who society views as “other”. I have therefore used this chapter to introduce the reader to the concept of transsexualism, and

in particular the transsexual woman. Furthermore, I have briefly framed the research problem and stated the objectives of this research. This chapter has also introduced the reader to the context in which the participants live and the challenges which they face on their sexual realignment journey. Basic terminology related to transsexual women and gender identity which will be used in this report have been highlighted. Together with the terminology, the organisation of this report was clearly set out. All of this is done to orientate the reader to the reporting of this study.

The next chapter of this report will introduce the reader to the theoretical framework on which this study was based, and my preconceptions and biases as the researcher will be noted.

Chapter 2 Theoretical framework

2.1 Introduction

In this chapter the theoretical and philosophical underpinnings which guided the study are presented. This research reports on the lived experiences of transsexual women negotiating health care in the hetero-normative healthcare system. Interpretative phenomenological analysis (IPA) was used as a methodology in this study and it is set in the interpretivist paradigm of inquiry. I also introduce myself as the primary research instrument and clarify the biases which I hold as the researcher.

2.2 Paradigm of inquiry

A paradigm is a set of beliefs with various philosophical assumptions guiding the approach to inquiry. In order to undertake quality research the researcher needs to understand not only the research approach, but also the philosophies and values which underpin the research method and paradigm (Duffy & Chenail, 2008). In interpretivism the social world is studied in its natural state, without intervention or manipulation by the researcher. People are deliberate and creative in their actions; they act intentionally and make meanings in and through their activity. Furthermore, in opposition to positivism people are not believed to act strictly as dictated by their culture and context, and are examined through the eyes of the participants rather than the researcher (Cohen, Manion & Morrison, 2007).

This study was conducted in a manner to adhere to the principles of interpretivism. For instance, data collection was conducted in a safe space that was chosen by each participant, including participants' homes where they felt safe, or restaurants when the participants felt that their home was not safe. The decision to conduct the interviews in a space deemed safe by the participant ensured that there would be no manipulation of the research setting, which would facilitate an authentic interview in line with the interpretivist paradigm. Through in-depth interviews participants could share their experiences with only minimal probing. This strategy awarded them the opportunity to elaborate on their context, and assisted me in understanding their life-world, which is different for each individual.

With IPA a strong focus is placed on the hermeneutic interpretation of the data during the analysis process. As the researcher it was my endeavour to make sense of the participants' experiences, which in turn was creating meaning of their own life experiences.

The findings of this research study are grounded in the voice of the participants. I ensured that thick descriptions were used in this report to validate the findings of this study. Grounding research findings on the voice of the participants is one of the fundamental tenets of IPA (Smith, Flowers & Larkin, 2009).

Case-by-case analysis was done from the data of each participant, whereafter a cross-case analysis was done. This allowed me to first place the focus on the particulars of each

individual before the data were analysed as a collective with cross-case analysis (Smith, 2004).

2.2.1 Theoretical underpinnings of method of inquiry

The methodological approach utilised in this study is IPA, a modern qualitative inquiry approach. This inductive approach combines the interpretative aspects of hermeneutics, with a focus on the particular as with ideography, as well as on lived experience as in phenomenological philosophy (Smith, Flowers & Larkin, 2009).

This study demonstrates both elements of description and interpretation. It was my aim to make sense of the sense-making of transsexual women in the healthcare system. This two-stage approach is described as double-hermeneutic and is a feature in hermeneutic phenomenology (Smith, 2004; Van, Bergum & Van, 2000). While the experiences of transsexual women are described in detail in the results section, my interpretation of the lived experiences comes to the fore in the discussion chapter.

The combination of various schools of thought in phenomenology in this study awarded me the opportunity to not only describe the experiences of transsexual women, but to successfully interpret these experiences in order to make an impact on the quality of health services provided to transsexual women.

2.3 The researcher as the research instrument

In this study I was the primary research instrument who facilitated the in-depth interviews in the data collection phase, transcribed the electronically recorded material into transcripts which could be analysed in the data management phase, and interpreted the data which are presented in this report. It is therefore important that I should clarify my position in this research upfront to allow the reader to understand my context as the researcher and to be upfront with regard to my biases.

I am a professional nurse, midwife, mental health nurse and nurse educator who has practised in the field of women's health. As a nurse educator I have been awarded with the opportunity to develop and support health professionals to render safe and appropriate care to the community, and to become activists for the marginalised. However, in the actual practice I realised that women in general are marginalised and oppressed, especially when they are black and of a lower social-economic and educational status.

On a personal level, I am a gender nonconforming man married to a gender nonconforming man. Society would label me as a homosexual man in a same-gender marriage. Through my own lived experience I understand what it means to live on the margins of society. I have dealt with being homosexual and Christian, being in a same-gender marriage and living an authentic life within a heteronormative world, and raising a child in a same-gender family crossing the boundaries of identity, sex, race, and culture. With the lived experience of being positioned at the margins of society I am internally motivated to challenge culture, policy and practices in society which are exclusive in nature towards the development of an inclusive culture.

It is through both my profession practising as a nurse, midwife, and nurse educator and personal experience that I have realised that even though I might form part of a minority group of people who are seen to be living on the margins of society, I have the means to live a fulfilling, authentic life due to being emancipated through education and privilege. Therefore I see it as my responsibility to assist other people who live on the margins of society to be able to live fulfilling, authentic lives.

The motivation in particular to investigate transsexual women who are on the journey of sexual realignment within the healthcare system is largely motivated by the fact that within the LGBTI community transsexual women remain the most marginalised subset. Transsexual women must not only deal with the fact that they have a sexuality which is different to the majority of the population, but also need to deal with issues of gender identity and embodiment.

2.4 Feminist research

Feminist research is concerned with the oppression of women. It gives a priority voice to the experiences of women and assists with the emancipation of women (Fayemi, 2009; Denmark, 2004). More recently Crowe (2011) refers to feminism as being *gynocentric*. He argues that feminism has an agenda focused on women's issues which are largely ignored by the mainstream debate (Crowe, 2011). This means that feminist research is research done by women, with a focus on women, in order to emancipate women. On a fundamental level this study was concerned with the experiences of marginalised and oppressed women, giving them the opportunity to express their experiences when they negotiated the healthcare system. As a gender-nonconforming man and a healthcare professional, I identified the need to give a voice to women who exist on the margins of society and the healthcare system. Therefore viewing this research through a feminist lens would be most appropriate.

2.4.1 Transsexual Women and Feminism

Some feminist theorists do not acknowledge transsexual women as organic women and thus do not accept them under the feminism umbrella. Raymond (1994) makes the statement "because transsexuals have lost their physical 'member' does not mean they have lost the ability to penetrate women – women's mind, women's space, and women's sexuality" (Raymond, 1979). During this period of the feminist movement feminists remained territorial about the feminist space and men were not privileged to this space as they were viewed as oppressors of women. Her argument is based on the belief that men and women are different and that no hormones and surgery could ever transform a man into a woman. She further argues that surgical sexual reassignment of MTF transsexual women is a strategy of men to infiltrate the women's movement. This thinking of man versus woman is rigid and fundamentalist, up to the point that it would classify all cisgender females (women who were born with female genitalia) as feminists and all cisgender males as chauvinists, and leaves no grey areas. This view would disqualify the transsexual women from being accepted as women and the researcher from viewing these women through a feminist lens. However, I believe that the mere fact that medical intervention and assistance can bring transsexual

women on a par with cisgender women, through the realignment of their physical bodies to their gender identity, allows transsexual women to be viewed through a feminist lens.

Recent feminist theorists (in a less harsh manner) still exclude transsexual women from the feminist movement. They question whether a person who was raised in male privilege can ever identify with women's experiences fully (Gottschalk, 2009; Jeffreys, 2008; Sweeney, 2004). While they stand in support of the rights of transsexual women, they still do not accept them as women. These feminists, although claiming to be oppressed, have become so exclusive in their thinking that they themselves who have been fighting this oppression have become the oppressors of the marginalised transsexual women.

As a health practitioner and researcher I believe that transsexual women are not men who are trying to infiltrate the space of women, and that they are able to identify with women. Hence my stance in using the feminist lens as the most appropriate lens while conducting this research.

Transsexual women are willing to and have renounced male privileges to become women. For instance, a USA study found that after transitioning, transsexual women's salaries dropped by one-third to match a woman's salary (Schilt & Wiswall, 2008). Furthermore, considering that while in the majority of the 53 African countries ascribing to any sexuality other than heterosexuality is deemed illegal and even punishable, we still find men who are willing to undergo realignment to become transsexual women; this shows that they are prepared to penetrate womanhood and risk going to jail and losing all privileges associated with being men (Anderson, 2007).

Transsexual women who are born and raised as male could never identify fully as men. Even if they do not opt for gender realignment themselves, they can remain vulnerable, marginalised and even unaccepted. These men fully understand what it means to be marginalised by their own, how to be excluded, abused and even oppressed.

On the other hand, trans-inclusive feminists like myself believe that issues such as equal employment equality and prevention of violence – which are some of the issues transsexual women face – are already in the feminist agenda, and while feminists have been debating the inclusion of transsexual women, transsexual women have been suffering (Connell, 2012; Namaste, 2009). As a gender nonconforming man in a country that was under apartheid for centuries, I understand what it means to be marginalised, unaccepted, ridiculed, and even oppressed. That has resulted in me choosing to be an activist for women who are oppressed and marginalised.

2.4.2 Males and feminism

Traditionally feminist research is conducted by women. However, more males have started to identify with feminism and conduct feminist research. There are various principles suggested in the literature that males should follow if they want to be conscious of the issues of women. According to (Schacht and Ewing (1997), a man who wishes to engage with feminism should:

1. Read feminist literature and listen to women's experiences;
2. Question his own potential to oppress women;
3. Reject traditional oppressive masculinity; and
4. Strive towards gender equality.

Prior to conducting this research, I actively engaged with feminist literature in order to gain an understanding of the theory and to be sensitised to the experiences of women. Since this study was a qualitative inquiry I spent an extended period of time just listening to the participants (transsexual women) in the study, and even more prolonged time to engage with the data collected from the participants.

Scott (2013) states that feminist theory defines men as being heterosexual and patriarchal. Should a man deviate from this heteronormative definition, he would be rejected from the masculine patriarchal world. She goes further to say that feminism has failed to include men like me, who do not fit the masculine and patriarchal mould (Morgensen, 2013).

2.5 Ontological assumptions

Crotty (2003) defines ontology as “the study of being. It is concerned with what kind of world we are investigating, with nature of existence, with the structure of reality as such.” This is echoed by Duffy and Chenail (2008) when they state that “Reality is the meaning or consciousness resulting from the embodied engagement of a person in the world” In this study I held the following ontological assumptions:

1. The subjective lived experiences of transsexual women are a reality.
2. The subjective experiences transsexual women experience in the hetero-normative healthcare system are real and need to be heard.
3. Transsexual women are marginalised, and the only way a difference can be made is not to write about them but to conduct research *with* them and to widely disseminate the findings of such research. This will give them a voice and contribute towards a better understanding of the needs of transsexual women.

2.6 Conclusion

This chapter focused on the theoretical and philosophical underpinnings which guided the research process. It indicates the paradigm of research, assumptions held by the researcher and how this research was conducted and viewed through a trans-inclusive feminist lens. This will inform the next chapter, which discusses the methodology implemented to conduct this research.

3.1 Introduction

In formulating, conducting and presenting this research literature played an integral role. In quantitative research there is consensus on the use of literature. It is used to create a map of the available literature and to identify shortcomings or gaps in the literature, which are used as a basis to formulate the questions, aims and objectives of the proposed study. In qualitative research there are different views with regards to when, how the literature is reviewed and the general aims of the use of literature (Creswell, 2014).

For instance, in grounded theory there is debate for and against conducting literature review prior to inception of a research study. Theorists who are of the opinion that a preliminary literature review should be omitted are concerned about the influence which available literature will have on the researcher and that it might be a cause of bias. Those who advocate for literature review are concerned about the time a researcher will spend on conducting research without knowing what is available, and then might be reinventing the proverbial wheel (Birks & Mills, 2011; Glaser, 2010).

This study was guided by the principles of IPA. In IPA research reviewing literature is utilised to widen the knowledge of the researcher and to assist with formulation of the research question through identifying shortcomings in the available literature (Smith, 2010). I reviewed available literature prior to formulation of the research question and the inception of this study, in order to give me an accurate perspective of transsexual women and their needs. This steered me towards the development of a research problem and the formulation of the research question, aims and objectives for this study. In reviewing literature prior to the study I could identify shortcomings in the current available research in the area, and together with the formulated question could decide on the most appropriate method to conduct this research.

Conducting a literature review in order to assist with formulation of the research question is supported by Creswell (2009), when he states that literature is used to frame the problem and that literature in qualitative research can also be used at the end of a qualitative study to compare and contrast findings. Taking various views with regard to the review of literature into consideration, I utilised literature in this study in the following manner. A preliminary literature review was conducted in order to carry out a study which will make a significant contribution to the already available research in the area of transsexual women and their health. Literature was also consulted throughout the process of research, and in the discussion chapter literature is used to confirm findings and to contrast the findings of this study with available literature.

3.2 Literature supporting the study

In reviewing literature to frame this research, the search for the literature was done electronically via the EBSCO host with specific inclusion and exclusion criteria. The search words that were used were: Transsexual/s and Health/Healthcare. All studies had to be peer reviewed and published in the English language. Studies from January 1972 up until February 2013 were included. The rationale for including literature as far back as 1972 was to hopefully gain a historical perspective as well as to cover the current debate in literature with regard to transsexual women and their health.

The following studies were included: All studies published in the Cinhal, Health Source, humanities International Complete, Medline, Psyc Articles and Soc Index databases which were found to be relative to transsexuals and health care. All studies that were specific to transsexual children were automatically excluded.

The initial search yielded 172 studies. Of the 172 studies, 105 were excluded due to the inclusion and exclusion criteria and repetition of studies on the databases. This step yielded 67 studies that were selected for the critical appraisal process.

A critical appraisal tool was utilised to measure the quality of the selected 67 studies (CASP International Network, 2014). After this process another 37 studies were excluded due to insufficient rigour or reliability, and 30 studies were finally selected for review.

The aim of the review was to explore issues related to the health of the MTF transsexuals nationally, regionally and internationally. Few studies were published nationally or regionally that fit the inclusion criteria. The review is organised under following headings: Health needs of the transsexual woman, Access to healthcare services, and Transsexual women and LGBTI communities in Africa.

3.2.1 Health needs of the transsexual woman

In the pursuit of gender realignment, transsexual women would undergo surgery and lifelong hormonal treatment as part of a treatment regimen. This regimen has an impact on the unique health status of transsexual women. Even though this treatment package benefits transsexual women, it significantly increases their need to visit healthcare practitioners for management of potential side-effects.

Literature demonstrates that the lifelong administration of feminising hormones can lead to an increase of both the systolic and diastolic blood pressure. Furthermore, it can increase insulin resistance in transsexual women (Elbers et al., 2003). Pulmonary embolism, deep venous thrombosis and osteoporosis can occur (Persson, 2009). Transsexual women require chronic management to treat conditions such as diabetes and hypertension. What makes these chronic conditions unique to the transsexual woman is that she is subjected to a regimen of lifelong hormonal treatment to facilitate and maintain her transitioning and sexual realignment.

The chronic condition of HIV/AIDS may affect transsexual women. Two large studies conducted in the United States of America (USA) identified that 40% of the participants reported inconsistent condom use. Less than half of the respondents made use of protection during their last sexual encounter, while 64% of the respondents reported having engaged in high-risk sexual activity during the past three months (Sevelius et al., 2009; Kenagy & Hsieh, 2005).

Transsexual women are anatomically more vulnerable to HIV infection due to the vulnerability of the tissue in the neo-vagina (Kenagy, 2002). The immediate question asked would be why this subset of the community would take such health risks, knowing that they might become infected with either HIV or other sexually transmitted infections. It is not clear if their attending health providers inform these women about the dangers of contracting HIV and other STIs.

Kenagy and Hsieh (2005) found in a needs assessment survey that MTF transsexuals believe that they will not become HIV infected and thus indulge in risky behaviour. HIV prevention programmes in South Africa target groups other than transsexual women. It is possible that the absence of health education for this group perpetuates the belief of transsexual women that they are not at risk for HIV infection.

Two USA-based qualitative studies concluded that transsexual women have a need to be accepted. They participate in high-risk sexual encounters to avoid rejection (Melendez & Pinto, 2007; Nemoto et al., 2004).

Two surveys conducted in Rome and California reported that 20% and 52% respectively of the transsexual women surveyed were HIV positive. It was noted that this was possibly an underestimation, since the respondents self-reported their HIV status (Edwards, Fisher & Reynolds, 2007; Verster et al., 2001).

South Africa has a female HIV prevalence rate of 17.4% (Statistics South Africa, 2013). This is high in comparison with international statistics. This elevated prevalence of HIV among women is a concern and could suggest an ever higher infection rate among transsexual women.

Transsexual women have an anatomical vulnerability, diminished negotiation power with regard to practising safer sex, and they are of the opinion that they do not form part of a high-risk group. This triple vulnerability which transsexual women carry to becoming infected with HIV is a concern, because it could contribute to the mortality and morbidity figures. It also raises the question as to why these women remain ignorant with regard to their risk, and how the healthcare system contributes to maintaining this ignorance. This remains a pertinent question in the South African context where the prevalence and incidence of HIV remain high.

Apart from physical health care needs, transsexual women are at great risk of mental ill health due to the dramatic changes experienced during their transitioning process. A USA-based survey of 446 transsexual individuals found that transsexual women have diminished

mental health as opposed to their heterosexual counterparts (Newfield et al., 2006). Hoshiani and others (2010) identified that 72% of transsexual women had suicidal ideation, which can be directly correlated to the poor state of their mental wellness. Furthermore, androgen deprivation that forms an integral part of the treatment towards gender realignment can lead to depression (Wassersug & Gray, 2011).

The prevalence of homophobia against LGBTI youth is high (McDermott, Roen & Scourfield, 2008; Scourfield, Roen & McDermott, 2008), and it is recognised that a higher suicide risk is present among these youth. It can be concluded that transsexual women may be at a higher risk because they are even more marginalised than other people of the LGB community and often suffer internalised stigma (James & Hays, 2011).

From the above it is clear that supporting the mental well-being of this subset of the community is challenging. This is exacerbated by homo- and trans-phobia, stigma and depression caused by androgen deprivation.

3.2.2 Access to healthcare services

Literature reviewed from international origin shows that access to available services for the LGBTI community remains largely limited, or there is a complete absence of healthcare services available to the transsexual community (Harawa & Bingham, 2009; Infante, Sosa-Rubi & Cuadra, 2009). In the USA African American transsexual women and uninsured, impoverished foreign-born transsexual women are reported to have the least access to healthcare services (Harawa & Bingham, 2009; Sanchez, Sanchez & Danoff, 2009).

Adequate access to healthcare and provision of hormone therapy significantly increases the quality of life of transsexual women. Of critical importance is the availability of trans-specific health education, which could positively influence their health risk behaviour patterns (Newfield et al., 2006; Bockting et al., 2005). Knowledge of healthcare providers about transsexual health issues is vital for access and utilisation of appropriate healthcare services.

In the USA a study of 101 MTF transsexual women found that a barrier to effective health care is limited access to a healthcare provider that has adequate knowledge about specifics of transsexual health (Sanchez, Sanchez & Danoff, 2009).

Another smaller USA-based study showed that specific health programmes do not acknowledge the LGBTI community (Scourfield, Roen & McDermott, 2008).

In a patient satisfaction survey on 180 transsexual women it was confirmed that transsexual women consider their healthcare needs important (Bockting et al., 2004).

Health professionals' attitude, such as respect and sensitive care, is another critical factor towards increasing access and utilisation of healthcare services by the transsexual women. This was highlighted in a study where it was found that transsexual women from Australia, America and Europe choose to have trans-related procedures performed in Thailand. The Thailand healthcare system is more accepting of the needs of transsexual women and the health professionals provide sensitive, acceptable care to transsexual women (Aizura, 2010).

Evidence suggests that having adequate access to trans-related health care is directly proportional to positive health outcomes for transsexual women. An improvement in the quality of health care provided to transsexual women will have a positive impact on the morbidity and mortality statistics of this group.

3.2.3 Transsexual women and LGBTI communities in Africa

Literature revealed that very little research has been conducted in Africa specifically with transsexual women and the LGBTI communities in general. This fact might strengthen the belief that this phenomenon is un-African (Rukweza, 2006). The limited research conducted and reported in Africa raises a concern with regard to evidence-based health care for these vulnerable communities. This void in the research debate compelled me to conduct scientific research with African transsexual women which will highlight their silenced voice within the African debate.

There are many reasons for lack of literature in the African continent. For instance, practising or displaying any other sexuality than heterosexuality is illegal and even punishable in the majority of the 53 countries that make up the African continent (Anderson, 2007). Therefore it would be extremely difficult and even dangerous for a researcher to conduct research and disseminate findings that place a focus on the LGBTI community in any of these countries.

Ehlers, Zuyderduin and Oosthuizen (2001) conducted a study in a Southern African country to assess the well-being of the LGBTI community. They reported difficulties of access to respondents, as non-heterosexuality is illegal, and that LGBTI individuals would choose not to disclose their sexuality to healthcare practitioners for fear of discrimination (Ehlers, Zuyderduin & Oosthuizen, 2001). This might lead to the provision of inappropriate health care. Although this study was on LGBTI people, it can be deduced that similar findings could be reported by transsexual women, who may also fear discrimination.

In another study conducted in three African countries it was observed that the HIV infection rate among the LGBTI community and particularly MSM (men having sex with men) groups was significantly higher than among their heterosexual counterparts (Fay et al., 2011). One of the issues highlighted was that the LGBTI community is not empowered with education on how to prevent the transmission of HIV.

In South Africa Chapter two of the South African Constitution proclaims that health care is a human right for all citizens. It states that each citizen has a right to healthcare services, including reproductive healthcare (Constitution of the Republic of South Africa [No. 108 of 1996], 1997). Furthermore, the National Health Act of 2004 aims to provide the best possible health services to the country. It is written that it protects and promotes the rights of vulnerable groups, including women, children, older persons and the disabled (National Health Act [No.61 of 2003], 2004).

Both the Constitution and other legislation are selective on the protection of the vulnerable people in the National Health Act. Legislation allows the transsexual woman to change her name and sex (Alteration of Sex Description and Sex Status Act, No. 49 of 2003, 2004);

however, the National Health Act does not specifically provide for the rights of the LGBTI community. The National Department of Health initiated and implemented various strategies to improve the health status of the South African population, but all of these initiatives are silent with regard to the LGB and in particular the transsexual community.

In an attempt to gain a historical perspective on the issue of transsexual women in the healthcare system of South Africa, I searched the databases as far back as 1972. Only one article referring to transsexual women was found, which was published in 1980.

In this article, presented as various case studies, Cairns and De Villiers (1980) attempt to showcase best practice with regard to gender reassignment surgery at their unit. An historical perspective is sketched to the development of vaginoplasty, and four cases of the creation of a neo-vagina in subjects are reported on with recommendations to practice in the conclusion of the article (Cairns & De Villiers, 1980).

The first question I asked in reviewing this article was regarding the ethical considerations. Did the subjects give consent to be photographed and reported on? The cases presented were reported as being successful. Where there ever any negative cases? Were all the gender reassignment surgeries successful? Unfortunately these questions remain unanswered as there is no mention made in the article of the ethical considerations which were observed.

The second issue with this article is the unnecessary presence of extremely graphic photography of the subjects. Even though the identities of the subjects are protected because their faces were not photographed, I am of the opinion that the amount of pictures published, together with the angle at which these pictures are taken, is unnecessary as there is adequate anatomical description of the procedures in the text. This article was written for an audience which is *au fait* with anatomical references; hence the use of such graphics is completely tautologous and borders on voyeurism.

The language style in this article is in itself shocking. The subjects in the article are perpetually insensitively referred to in the masculine. Furthermore, comments of judgement are made about perceived compliance to treatment by the authors. The subjects are reported on in an almost non-human manner. (Hence I am using the term "subject" instead of woman when referring to this particular text.) The only focus in this text is the physical creation of a neo-vagina, and success is measured in the depth and patency of the vaginal passage by means of surgical intervention. All other aspects of the human person are ignored.

The limited research on the health needs of the transsexual women and the LGBTI community in Africa is of great concern. It demonstrates the need for this proposed research, which aims to generate new knowledge and provide an evidence-based foundation for health care of these communities.

3.3 Reviewing literature to find appropriate methodology

Through reviewing the global, regional and local literature, I formulated the research question: What are the lived experiences, and meaning of these experiences, for transsexual

women during the sexual-realignment process when negotiating health care for their transgender-related healthcare needs in the healthcare system? The next step was to look critically at the literature in order to find the most appropriate paradigm in which to frame this research. Two main streams of research were uncovered in the process. The first research stream is research conducted on transsexual women, while the second stream is investigations done with transsexual women.

3.3.1 Research conducted on transsexual women

Technology, technique and treatments are continually improved, developed and made safer in the medical world. This is evident in research done especially in the medical field pertaining to the treatment options available to transsexual women.

For instance, systematic reviews and case reports are used to find best practice with regard to surgical sexual realignment and case study reports to disseminate innovations in the field of trans surgery (Jarolím et al., 2009; Sutcliffe et al., 2009). With regard to making the administration of lifelong feminising hormones safer, randomised control trials and quantitative cross-sectional studies are often the choice of inquiry which researchers implement (Reutrakul et al., 1998 Emi et al., 2008).

When studies with the purpose of gathering epidemiological data of transsexual women are performed, the paradigm of inquiry is quantitative and surveys are used to collect data. This is seen in studies where HIV infection among transsexual women is researched and issues such as transsexual identity and suicidality (Kenagy & Hsieh, 2005; Mathy, 2002). Other strategies implemented to collect data on these areas of inquiry include online anonymous surveys and self-administered questionnaires (Ramirez-Valles et al., 2008).

Studies of this nature are greatly important. Firstly they assist clinicians with updating their skills in order to provide better and safer treatment options to transsexual women who are on the journey of sexual realignment. Secondly, it is also useful to have data on the risk and risk behaviour of transsexual women, which could assist with the development of appropriate strategies to reduce risks such as suicide and risky sexual practices.

Although these studies have value and are important to healthcare practitioners, as a feminist researcher I find that such research conducted on transsexual women is of greater value to healthcare practitioners than transsexual women. In these studies transsexual women are studied as research subjects who will assist medical practitioners to improve their practice, with a benefit to transsexual women in future who might reap some reward.

3.3.2 Research conducted with transsexual women

Juxtaposed to research conducted on transsexual women is a paradigm where research is conducted with transsexual women, even though many of the same issues are inquired into. For instance, exploring risky sexual behaviour and HIV prevalence among sex workers was done qualitatively using face-to-face in-depth interviews to gather data or conducting focus groups to investigate the social context in which transsexual women of colour take sexual risks (Reback et al., 2005; Nemoto et al., 2004).

Research conducted with transsexual women often yields in-depth accounts of the experiences of these women, and can take the form of a single case study to highlight the challenges in the context of a particular woman or larger qualitative studies utilising purposive sampling and using semi-structured interviews to gather data (James & Hays, 2011; Alegría, 2010). Not only does this paradigm of research yield in depth accounts of transsexual women in context, but through facilitating participatory action research, a social model of health can be constructed (Monro, 2000).

When research is conducted with transsexual women it usually takes on the form of a qualitative inquiry. Such studies do not yield data that can easily be generalised, but do provide an in-depth perspective into the phenomenon under investigation which could be transferred into similar context.

Conducting research with transsexual women places them in a position of equality with the researcher, rather than as a passive subject being investigated. This type of research is key to implement in marginalised populations such as transsexual women, as their voice is often silenced in the general debate. Through empowering research strategies, these women can be awarded a voice through the interpretation of the researcher.

The formulated research question necessitated this research study to be conducted in the qualitative paradigm in order to award justice to the voice of transsexual women in an African context. This fact, together with my feminist views as discussed in the previous chapter, allowed me to perform rigorous scientific research with transsexual women with the greater aim of improving the healthcare which they receive.

3.4 Conclusion

This chapter provides the reasons for conducting a literature review in a qualitative study, especially when IPA is used as a methodology to conduct a study. Furthermore it highlighted the dearth of literature on transsexual women in the African context, thus supporting the need for this study.

This chapter also clearly demonstrated the difference between research done on transsexual women and research conducted with transsexual women. It validates the choice of methodology implemented in this research to work with women in order to generate quality scientific research while ensuring justice for the women who participated in this study.

The following chapter will introduce the reader to the research methodology followed in this project, and it will clearly describe the research method as implemented in order to generate the data which were used for interpretation.

Chapter 4 Methodology

4.1 Introduction

This chapter introduces the reader to the methodological aspects of this study. The choice of the most appropriate methodology is argued and a clear account of the method given. The chapter also presents the steps taken to ensure the ethical soundness of the study.

4.2 Methodological choice

In investigating the journey of sexual realignment of transsexual women in a heteronormative healthcare system, the overarching research question undoubtedly called for an inductive approach to research. Interpreting the experiences of transsexual women needed me to come to an in-depth understanding of the life-world of transsexual women. This would have been impossible to achieve using quantitative methods; hence two interpretative qualitative approaches to research inquiry were explored.

4.2.1 Grounded theory

Using grounded theory as a method of inquiry was considered because it is deemed appropriate to be used in under-researched areas such as the experiences of transsexual women in a heteronormative healthcare system. One of the aims of grounded theory is also to take qualitative research beyond mere description and elevate it to the level of interpretation, which was also of interest to me as I am of the opinion that descriptive evidence would not assist health practitioners to improve healthcare delivery to transsexual women.

Grounded theory was developed in the 1960s by the sociologists Glaser and Strauss. This methodology was developed in response to the critique of positivists, who believed qualitative research is subjective and lacks the necessary rigour. They also held a strong belief that theory should not only be tested, but a methodology should be developed to generate new theories (Glaser & Strauss, 1967).

This methodology uses qualitative data to develop theory, which may take on the form of theories, frameworks or conceptual models, through a rigorous process of theoretical sampling, constant comparative analysis, and using literature as a source of data (Birks & Mills, 2011; Elliott & Jordan, 2010; Charmaz, 2006).

I decided against the use of grounded theory as a methodology to guide my study for two main reasons.

The first reason is the fact that a researcher doing grounded theory should not have any preconceived ideas about the topic (McCann & Clark, 2003). In classic grounded theory it was expected that no preliminary literature review should be performed (Glaser & Strauss, 1967). This view might have changed with modern grounded theory, yet it was impossible for me not to have any preconceived ideas about this study due to being an advocate for the

health and rights of the LGBTI community. I had to find a methodology which would allow a researcher to embrace my preconceived ideas, but implement effective bracketing strategies in order to report an unbiased account.

The second reason for excluding grounded theory as a methodology was the fact that grounded theorists do not explicitly describe the methodology of grounded theory (Lyons & Coyle, 2007). Although Charmaz (2006) and Birks and Mills (2011) have written texts in order to describe the methods to be used in grounded theory, I am not convinced that the methodology as described by these authors is clear enough and could leave a significant audit trail.

4.2.2 Interpretative phenomenological analysis

The roots of IPA stem from psychology, and it has been widely used in nursing research as well (Mathias, Parry-Jones & Huws, 2014; Stewart & Rae, 2013; Yuen-ling Fung, Zenobia & Wai-tong Chien, 2013; Vachon, Fillion & Achille, 2012; Pringle et al., 2011). This approach is a synergy of phenomenology, hermeneutics and ideography. This modern approach to qualitative inquiry was found to be the most appropriate method of inquiry for this study for the following reasons:

- This methodology awarded me the opportunity to investigate the healthcare system through the interpretation of the subjective lived experience of transsexual women (Bezance & Holliday, 2014; Wagstaff & Williams, 2014; Pringle et al., 2011).
- In reporting IPA research emphasis is placed on the details of the experience of the participant. Therefore the voice of transsexual women, which is often silenced in the general debate, could be awarded justice in this study (Bezance & Holliday, 2014; Flowers et al., 2011; Reynolds & Shepherd, 2011).
- IPA has been successfully used in research of niche populations, which makes it applicable for conducting research with a small population of transsexual women who are not easily identifiable (Wagstaff & Williams, 2014).
- This study was conducted within health sciences. In the 1990s IPA as a methodology was developed in psychology and has been tested and proved to be a scientifically rigorous method of inquiry for health science research (Biggerstaff & Thompson, 2008; Brocki & Wearden, 2006).

4.2.2.1 *Phenomenology*

Phenomenology has its roots in philosophy. The three main philosophers who described and practice phenomenology are Husserl, Heidegger and Merleau-Ponty. All three of these philosophers were concerned with the lived experience of people in their own context and their understanding of such experiences. Husserl was interested in the description of the experiences of people, while Heidegger and Merleau-Ponty moved more towards the interpretation of such lived experiences of people. All of the phenomenological writers base their philosophy on reflection of the experience of individuals connected to their context (Morris, 2012; Heidegger & Stambaugh, 1996; Kockelmans, 1987).

IPA research is reflective in nature and places a great emphasis on understanding the experiences of people in their context. The IPA researcher attempts to interpret the experiences of people while they themselves are trying to make meaning out of their reality.

In this research I adopted a phenomenological attitude whereby I entered the life-world of transsexual women naively with an open and curious mind. Conscious efforts were made to bracket my own preconceptions which I have acquired through literature and life experience. I had to constantly reflect on my preconceived ideas in order to enter each interview as naïve as possible (Finlay, 2014). While entering the research with a naïve attitude, I fully immersed myself in the data to move from mere simple understanding of the phenomenon towards interpretation of the experiences of transsexual women.

4.2.2.2 *Hermeneutics*

The aim of IPA research is to be interpretative in nature, as its name implies. Hermeneutic theorists are specifically concerned with the interpretation of text in the context at which it occurred. The analysis is done in a cyclical process with interplay between the parts and the whole in order to articulate an interpretation of a phenomenon. This manner of approaching data is in line with hermeneutic philosophers (Babich & Ginev, 2014; Gadamer, Weinsheimer & Marshall, 2013; Smith, 2010).

Hermeneutics stem from the interpretation of historical and biblical texts and a critique of the methodology might be that it will not be able to capture modern phenomena such as investigated in this particular study (Porter & Stovell, 2012; Botta & Andinach, 2009; Goldsworthy, 2006). However, hermeneutics have influenced IPA greatly with regard to interpreting contemporary texts.

Even though the phenomenon of transgenderism has been around for a long time, the phenomenon of transsexual women can be viewed as contemporary as the technology has only become available to assist transgender people to medically and surgically realign their bodies with their gender identity in the latter part of the 20th century. In this research I made sense of the experiences of ten transsexual women in how they negotiate the healthcare system. This was a double hermeneutic process and assisted in elevating the collective experiences of ten transsexual women into synthesis.

4.2.2.3 *Ideography*

Ideography places the focus on the particular and rejects the often used nomothetic analysis which makes claims on a population level, often used in qualitative research. A more case-specific analysis is followed in ideography. The result of ideographic research is an interpretation of rich accounts of a singular case (Smith, Harré & van Langehove, 1995).

IPA takes an ideographic approach in its analysis whereby data are analysed as a single case. However, in IPA research it is common practice to investigate more than one case at a time in order to articulate more general statements, while the focus and detail of each case analysed will still be given justice in the dissemination.

In this research I analysed each of the ten interviews as a unit before I moved on to interview the following participant. After this process analysis was done across the ten units. This assisted me with synthesis and allowed me to claim that there is consensus in the lived experiences of the participants in this research. However, implementing an ideographic approach to the analysis of the data in this research, the detail of the experience of the participants remained and I have clearly demonstrated this in this report through the quotes of the participants.

4.2.2.3 *Bringing it together*

In harnessing the strengths of phenomenology, hermeneutics and ideography, IPA sets out to interpret modern phenomena through well-documented, structured analysis procedures which guide an iterative analysis process and a thick description to complement the interpretation. IPA has been criticised by Giorgi (2010) as being unscientific and lax (Giorgi, 2010). However, these claims have been adequately rebutted in the literature by Smith (2011), and a track record of the science of this methodology exists in the literature (Smith, 2011). Therefore this method is the most appropriate approach for the investigation into the experiences of transsexual women within the healthcare system.

4.3 Population

The population under investigation in this study was transsexual women living the Western Cape Province of South Africa. The population size is unknown as there are no reliable statistics in South Africa which include transsexual women in order to make a population estimate.

4.3.1 Sample and sample size

A sample of ten transsexual women was selected to participate in the study. Inclusion and exclusion criteria were applied in the selection of the identified participants as discussed later in the chapter. The sampling process was concluded with the tenth participant as it emerged through the analysis that theoretical saturation had been reached, as emergent themes started to be replicated.

This inductive study investigated the particular journey of a small population in a specific geographical context in order to understand the life-world of transsexual women. IPA allowed me to understand this phenomenon in context through the detail of the experiences and understanding of the participants.

Although there are recommendations which state that qualitative studies should include a sample of between 20 and 30 participants, in IPA research sample sizes of smaller than ten are selected to attain sufficient depth and provide justice to the experience of the selected participants (Mason, 2010; Smith, Flowers & Larkin, 2009).

The sample of ten participants is at the top end of the sample size scale for an IPA study, but I continued sampling until theoretical saturation was reached, which occurred with the tenth

participant (Bowen, 2008; Bernard, 2002). This allows me to make the claim that consensus was reached among a sample of ten participants without compromising on the depth of the investigation.

4.3.1.1 *Inclusion criteria*

In order for participants to have been eligible to participate in the study they had to meet the following set of inclusion criteria; a transsexual woman who:

- Is over the age of 18 and currently on the continuum of sexual realignment;
- Is using life-long hormonal treatment, with or without having had sexual realignment surgery; and
- Is utilising the public/private healthcare system for her trans-related health problems.

4.3.1.2 *Exclusion criteria*

Women who did not meet the inclusion criteria or who met the exclusion criteria were automatically excluded.

A transsexual woman who had suicidal ideation and acted upon it in the past three months would have been automatically excluded from the study. Literature states that transsexual women have a higher incidence of depression and associated suicidal behaviour than the general population. In understanding the vulnerability of the population and potential of trauma in sharing personal experience, such a woman would be excluded to protect her mental well-being.

To determine the exclusion criteria, the following questions were asked at the first meeting with a potential participant:

1. Have you had thoughts of harming yourself in the past three months?
2. Have you tried to harm yourself in the past three months?
3. Do you sometimes feel that you have nothing to live for?

Should she have answered yes to one or more of the abovementioned questions, she would have been excluded from the study.

4.4 Pilot study

Prior to inception of the main study a pilot study was conducted. The purpose of the pilot study was to implement the methodology on a micro scale to ascertain its viability. It also assisted me with development of the research plan (Kim, 2011). The pilot phase of the study started in August 2013 after ethical clearance was granted by the University of Cape Town Health Research Ethics Committee, and was concluded in November 2013.

In this study I was the main instrument used for data collection, and the pilot study provided an opportunity to test the responses collected against the interview guide and the objectives

as set out earlier in the thesis. Kim (2011) confirms the appropriateness of conducting a pilot study in qualitative research in order gauge the quality of oneself as the research instrument and reflect the appropriateness of questions contained in the interview guide.

Besides review the research instrument and questions, the pilot study gave me the opportunity to determine if the sampling strategy as planned for this study would be effective. Four participants were recruited into the pilot study. The choice to include four participants was influenced by the guiding factor that the sampling process which included purposive and snowball sampling had to be tested.

I purposefully wanted to include both rural and urban participants in the study; hence the recruitment of the first participant from a rural area in the Western Cape. The first participant was introduced to me through the key informant. During the proposal development stage, together with my supervisor we had a meeting with the management of Gender Dynamix. Gender Dynamix is a Cape Town-based non-governmental organisation (NGO) that does advocacy and community outreach work with transgender people across the Western Cape Province. They are also involved in assisting transgender people to gain access into the healthcare system for sexual realignment treatment. I informed them of my proposed study, and they agreed that this research would have a positive impact on the treatment and care of transsexual women. It was at this meeting that I was introduced to Gender Dynamix's community outreach worker, who could act as a key informant and could facilitate access into the community of transsexual women in both the rural and urban areas of the Western Cape.

This initial participant from rural decent satisfied the inclusion criteria and was included in the study. After the interview was conducted, she was asked to refer possible participants who could be included in the study. She gave the names and numbers of two possible participants. One referral was an urban woman and the other a rural woman.

I contacted the rural woman and made an appointment to see her at her home. During the initial information session, when I explained the study and the inclusion criteria, it was found that although the woman is willing to participate in the study and she identifies as being transsexual, she has never used feminising hormones. She was excluded from the study, but she was asked to refer any women she knew who could possibly participate. She gave me the contact details of one woman also from a rural area.

Through the experience of setting up an appointment to see a participant and finding that she did not satisfy the inclusion criteria, as with the previous woman, I asked the referred woman key questions telephonically upon initial contact to make sure that she did satisfy the inclusion criteria before I would have to drive 400 kilometres only to find out that she did not qualify to participate. An appointment was made with the woman where we would have a face-to-face information session and possible interview.

The interview was conducted at the woman's home after informed consent was negotiated. This participant made use of off-code feminising hormones. The hormones which she uses to

aid her in her feminisation are hormones which are registered for use as contraceptives and are given to her by a healthcare worker who is her friend. The hormones are dispensed on a six-monthly basis without the necessary consultation, health screening and monitoring. This participant lives an extremely sheltered life and does not have contact with other transsexual women. She could not give me any referrals to be used in the snowball sample.

The urban woman referred by the first participant was never contacted, as I wanted to test the sampling strategy starting in the urban parts of the Western Cape.

Purposive sampling is often utilised in qualitative research, whereby the researcher will scout for participants who they consider to have the best experience to satisfy the objectives of the research. Furthermore, in various IPA studies researchers have used personal networks to gain access to possible participants. In studies conducted with the LGBTI community researchers have visited gay bars and other social meeting places in order to identify possible participants (Davis & Flowers, 2011). Times have changed, and with the aid of technology networks have become easier to enter, even from home via the internet and social media applications. A social media application assisted me to purposefully find possible participants. With Facebook people have fairly publicly visible profiles which contains personal information visible to the public; it is through these profiles that I could identify possible participants.

After browsing through the social network Facebook I contacted an urban transsexual woman with a discrete inbox message. In the message I explained to her that I am conducting research with transsexual women, and she could contact me should she be interested to participate in such a study. She replied with her telephone number and informed me that I could contact her.

After I explained the study to her telephonically, she asked me to have the information session and possible interview in a public space, as she did not have a safe space at home where we could meet. She did not deem her home to be a safe space as she is living with family in a small flat with extended family who barely tolerate her existence. The interview was conducted in a coffee shop in a shopping mall. After the interview she made three referrals, of which one was followed up for the pilot study.

I contacted the fourth possible participant for the study telephonically. Through having the experience of having to conduct the previous interview in a shopping mall, I offered to meet with the participant either at her home or at my office. She elected to meet with me at my office as it was convenient for her, because she could meet me on the same day as her clinic appointment which was in the same building as my office. At the conclusion of this interview the participant gave me the names and telephone numbers of three women who could be contacted as part of the snowball sample.

The interview schedule consisted of two parts. The first part had nine closed-ended questions which collected biographical information from the participants. These questions were easy

to answer and acted as an icebreaker. This endeavour proved to build rapport between myself and the participants before I posed the in-depth questions.

The second part of the schedule consisted of ten questions which were related to the objectives of the study. I realised after the first interview that there are certain questions which would not be applicable to some of the participants. An example would be that the questions which dealt with surgery were not applicable to participants who were pre-surgery. However, the issue of surgery did come up throughout the interview. It also became apparent that not all questions would be applicable to all the participants when I interviewed the participant who made use of off-code feminising hormones.

These responses required me as the primary research instrument to adapt my questioning and allow for a more in-depth interview with less structured questions. It led me to listen to the responses of the participants and ask appropriate probing questions which allowed participants speak to the objectives of the study.

After each interview the recordings was transcribed verbatim and analysed according to the steps of analysis for IPA.

The pilot study informed the main research project both on a practical and methodological level. On a practical level I identified strategies to streamline the research process which ensured the economical use of resources. Furthermore, I identified a need to be debriefed as the key instrument of this research. Methodologically, telephonic screening was added to enhance the sampling approach, and I made adaptations to my interviewing style. These changes were duly discussed with the research supervisor. There was no need to have these changes served to the ethics committee, as the ethics of the study was not compromised and the methodological and practical adaptations which were effected did not influence the objectives of the study. In fact, they enhanced the rigour of the study.

4.4.1 Practical lessons learnt

Interview sessions were conducted in a safe space identified by the participants (Duma, Khanyile & Daniels, 2009). I soon realised after the initial interview that this measure was quite costly, as I had to drive far distances to meet with the participants. For the first participant I had to make a round-trip of 800 kilometres and had to find accommodation in the town where the interview was conducted, as it would have been taxing to drive back to Cape Town on the same day.

The cost issue became more apparent when I visited the first referral only to find out that she did not meet the inclusion criteria. This led me to ascertain if a possible participant met the inclusion criteria telephonically before I set up a meeting to have the information session and possible interview. This would hopefully prevent another situation where I would drive far to meet with a possible participant and find out that she did not meet the inclusion criteria. This strategy would save time and money.

Furthermore, I realised that even though I wanted the women to indicate the safe space where the interviews could be conducted, it had to be managed. It was quite difficult to transcribe

an audio-recording which was done in a public space. Even though I made use of modern high-tech recording equipment, there was a lot of 'noise' in the recording. Upon reflection, after the data analysis of the participant who elected to have her interview in a coffee shop, I was of the opinion that there would have been more depth in the data should it have been conducted in a more private location.

The pilot study gave me an indication of time needed to conduct the interview, transcribe the recording and analysing the data. The interviews were on average one hour long. Transcription of one interview took about ten hours, and analysis of the transcribed data took roughly 40 hours per transcript.

In the initial proposal provisions were made to refer participants for counselling should they experience distress during the data collection process. I however realised that I would need debriefing sessions after conducting an interview session. During the interview sessions various traumatic events were discussed, such as hate-rape and physically violent transphobic attacks. As a person who identifies as a sexual minority, I could identify strongly with the experiences of the participants, and I was not only faced with this trauma during the interview process, but had to engage with the issues throughout the transcription, analysis and writing-up process. I made regular appointments with a psychiatric nurse with the sole purpose of having debriefing sessions.

4.4.2 Methodological lessons learnt

The sampling approach proved to be viable. The only adjustment which was made was to have a telephonic screening with possible participants to ascertain if they would satisfy the inclusion criteria prior to our physical meeting. This measure was taken to save time and money, as it would prevent me from travelling long distances only to find that a possible participant did not meet the inclusion criteria.

The interview schedule initially had nine questions which guided the interview process. After the first interview I realised that there are more in-depth issues which arise during the interview and warrant being explored as they contribute positively to the objectives of the study. As the interviewer and primary instrument for data collection in this study, I learned to become comfortable with silence and allowed the participants to elaborate on their answers with minimal interruption. This freedom in the interview was allowed as long as the conversation added value to the research. This reflection assisted me to develop the interviews more into an in-depth conversation, rather than a session where the researcher would pose structured questions which the participants answered.

The results of the pilot study necessitated the following improvements to the research plan:

- Screening participants telephonically before the face-to face-information session;
- Allowing participants to indicate a safe space for the interview, but making my office available as a venue to prevent interviews being conducted in public spaces;
- Planning debriefing sessions for myself after an interview; and
- Adaptation of my interviewing style to an in-depth conversation.

Even with the adaptations that had to be made to the research plan, the pilot phase of this project proved that the research plan was viable as the following parts of the research plan worked:

- Using the key informant to gain access to the population;
- Contacting possible participants via social media;
- The purposefully selected participants could give me enough referrals for effective snowball sampling;
- The interview schedule generated rich data which satisfied the objectives of the study.

4.5 Inclusion of pilot study results in the main study

It is practice in quantitative research not to include the data collected in the pilot study in the analysis of the main study. However, in qualitative research this practice has been done successfully without compromising the quality of the research (Van Wijk, 2010; Duma, 2006). I have included the data of the pilot study in the analysis of the main study for the following reasons:

- The population of transsexual women is small and they are not easy to find, thus it would not be wise to discard valuable data
- There were no major changes made to the interview schedule after the pilot phase
- The data collected during the pilot phase was of a rich nature and satisfied the objectives of the study
- As a feminist researcher, it is my opinion that I would do an injustice to the voice of marginalised transsexual women by discarding their data and not include it into the main study.

4.6 Recruitment strategy and sampling process

It was of great importance that recruitment and sampling were conducted in such a manner that the women continued to feel safe throughout the process, as transsexual women are deemed as marginalised people and are vulnerable (Anderson, 2007). As a researcher it was also my ethical responsibility to maintain confidentiality and their dignity. Recruitment and sampling commenced in August 2013 and was concluded in March 2014.

The initial purposeful sampling approach yielded five participants, who were recruited either through a key informant, via social media or through direct contact. The five selected participants provided contact details of other transsexual women whom they deemed to be eligible to participate in the study, and through this snowball approach another five participants were selected.

Purposeful sampling allowed me to select participants who could best inform the research question, while snowballing assisted the researcher to find hard to reach participants who also had the appropriate experience which could adequately inform the research question (De Vos, 2011).

A community worker from a Cape Town-based NGO, who works with transsexual women, was used as a key informant to facilitate access into the transsexual community. She acted as an intermediary between the researcher and the population to facilitate access to transsexual women who could possibly participate in this study (Clark, 2011). Through this community worker I was introduced to two women who were selected to participate in the study.

I utilised social networks in order to contact women who might be eligible to participate in the study, using the social platform Facebook. Through my personal online social network I could follow women who might have been eligible to participate. A discrete private message was sent to possible participants, which included some background to the study, and the women were asked to make contact with me should they want more information on the study. This measure yielded another two participants.

The fifth purposefully sampled participant in this study was known to me prior to the inception of this study. I approached her personally and asked her if she would be interested to participate in the study.

From the five participants who were purposefully sampled, 11 referrals were made to be used as a snowball. Five of the 11 contacts were included in the study, while the rest of the participants were either excluded or not contacted when theoretical saturation was reached or they failed to meet the inclusion criteria. The diagram below schematically represents the sampling process. *Nom de plumes* are used to protect participants' identity.

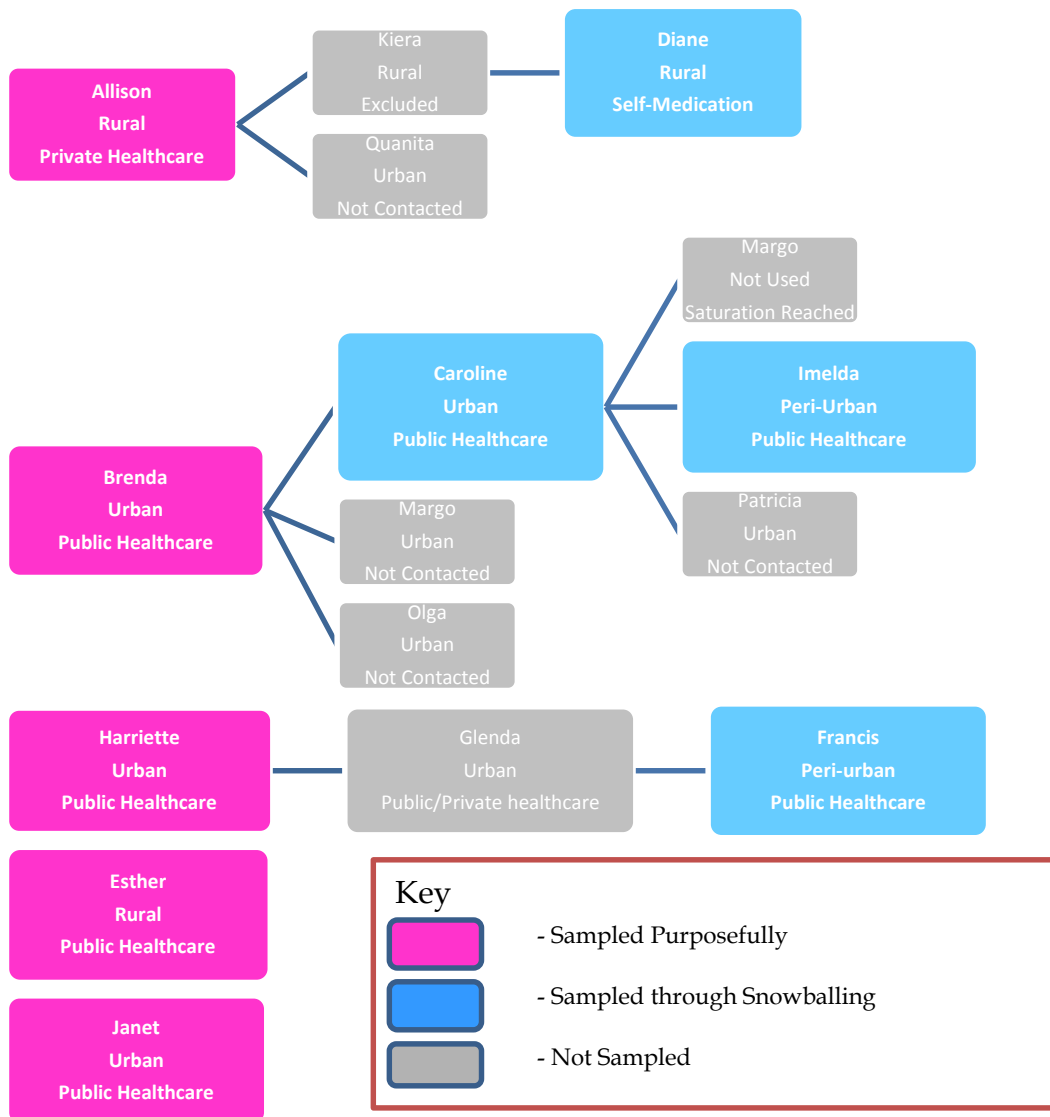


Figure 4.1. Schematic representation of the sampling process

4.7 Recruitment process

After initial contact was made with the women via the key informant or social network, I phoned each possible participant.

During the telephonic conversation I introduced myself and aspects of the study, and I would ask the woman if she would be interested to have an information session and possible interview to explain the study and possible participation. All participants were given the option of deciding on where the meeting should take place. I also gave them the option of using my office should they not have a safe space where the meeting and possible interview could be conducted.

Qualitative research is often conducted in the natural environment of the participant, which in this study would be the home of the participant. However, participants might not deem their home a safe space to conduct a research study, hence the option of conducting the interview in my office to ensure the safety of the participant (Duma, Khanyile & Daniels, 2009). This strategy made participants feel safe and secure and in turn assisted with the

building of rapport between the participant and the researcher (DiCicco-Bloom & Crabtree, 2006). This autonomy given to participants built immediate trust between the participant and myself, and they felt comfortable to share intimate information.

Seven of the participants opted to have the information session and the subsequent interview in their homes, one participant opted to have the meeting and interview in a coffee shop, one participant elected to have the information session and interview at her place of work, and one participant came to my office as it was convenient for her as she attended the clinic in the same building as my office.

During the information session I reintroduced myself and explained the purpose of the study. An information leaflet was given to each participant explaining the study (Appendices A and D). After I explained the information leaflet to the participant, I took time to answer any questions and concerns the women had.

During this time consent was negotiated. It was however stressed that participation in this study was voluntary and that under no circumstance should the participant feel that she had to give consent just because I came to see her for the information session. All the women who were contacted to participate in this study gave voluntary consent and the interviews were conducted directly after the information session.

Each participant was informed that she would be compensated R100 for her time offered to participate in the study. This practice is widely accepted in research and was cleared with the ethics committee of the University of Cape Town (Kwagala, Wassenaar & Ecuru, 2010; Sullivan & Cain, 2004). It has also been implemented locally by researchers working with vulnerable women (Duma, Khanyile & Daniels, 2009). It was carefully explained to each participant that the compensation is not intended to coerce them into participating in the study, but is merely a means to compensate them for their time.

From the ten participants three blatantly refused any compensation. All three of them stated that it is important for them to be able to tell their story, and they do not want to be compensated for it. They are happy if they can assist other transsexual women with their experiences.

After informed consent was negotiated and the informed consent document was signed (Appendices B and E), the interviews commenced.

4.8 Description of the sample

The sample of participants who participated in this study can be described as eclectic. Their ages ranged from 27 to 70 years. Three of the women live in rural parts of the Western Cape, two reside in a peri-urban area, and while five live in and around the City of Cape Town. Their racial and cultural backgrounds were also different and represented the population demographics of the Western Cape. Two of the ten women were post-surgery, while the other eight were pre-surgery. One woman made use of off-code hormones to aid her transition.

4.9 Data collection

In IPA research a focus is placed on the intimate experiences of participants. The data collection strategy should be set out in a manner to collect rich, multi-faceted data which will do justice to the analysis process and would in turn give the researcher and reader an in-depth insight into the life-world of the participants (Smith, 2010).

In acknowledgement that the issues which transsexual women face are sensitive, and with the assumption that transsexual women are vulnerable, the data collection process was performed in a sensitive manner through conducting in-depth interviews in a private location identified by the participant herself.

In-depth interviews allowed me to become immersed into the life-world of the participants over the eight-month period during which the interviews were conducted, while it gave the participants ample scope to freely tell their stories while I mainly took on a passive listening role. Freedom was given to participants to elaborate on their stories. Appropriate prompts and probing questions were posed to the participants in order to gain a deeper perspective on an issue, or for clarification purposes. I consciously guarded against too many probes and prompts to prevent a breakdown in the flow of the conversation. This strategy also prevented me from leading the conversation into a particular direction and could minimise bias from entering the data.

For instance, one participant made mention of violence which she has experienced. She said that she did experience violence and she is public about it in order to assist other transsexual women, after which a long silence persisted. In order to gain more clarity on the matter I asked her if she is willing to talk about it. She shared her whole experience of being a victim of hate-rape and how she was failed by the healthcare and the judicial system.

Having the interview questions and objectives in mind, participants were allowed to tell their stories freely. It did however happen in some interviews that participants started to discuss issues which were completely off the topic. In these circumstances I gently steered them back on track with prompts like: *"Thank you, the story which you are telling me is extremely interesting. You told me about how the doctor responded when you visited Hospital X, could you tell me how his response made you feel?"*

4.10 The interview schedule

The interview schedule consisted of two parts. The first comprised short, closed-ended questions which yielded a demographic profile of the participant. These questions were also included to act as an ice-breaker, which allowed the participant to become comfortable with the interview set-up. The questions were non-threatening and participants could easily answer them.

The second part of the interview schedule consisted of open-ended questions which were directly aligned with the objectives of the study, posed at a level of understanding of the participants and giving them the opportunity to respond in a narrative manner.

For instance, the objective *To explore, and analyse the current health-seeking behaviours and experiences of transsexual women in negotiating health care for their transgender-related health needs*, was linked to the following questions:

- Have you been to the health service, e.g. clinic or hospital, for any of the hormone therapy-related problems? If so, please tell me what your experience during these visits has been?
- How did the nurses and doctors respond when you explained your health problems and asked for help?

Nine open-ended questions were posed to the participants, which led interview encounters to be on average one hour long, which is in-line with standards set for the amount of questions posed to a participant in IPA (Smith, 2010). (See Appendices C and F: Interview Schedule.)

4.10.1 Language

Afrikaans, Xhosa and English are the three most common languages spoken in the Western Cape. The English interview schedule was professionally translated into Afrikaans and Xhosa.

I gave the participants the option to have the interview conducted in Afrikaans, Xhosa or English. Although all of the participants could communicate in English, five of the ten participants elected to have their interview conducted in Afrikaans. They felt that they would be able to express themselves better in Afrikaans rather than English. None of the participants elected to have their interview conducted in Xhosa.

The Afrikaans interviews were initially transcribed in Afrikaans and a professional Afrikaans/English translator translated the transcripts into English. The English and Afrikaans transcripts were compared by a bilingual expert and myself. To ensure greater quality, I would listen to the Afrikaans interview recordings while reading the translated transcripts, as I am proficient in both English and Afrikaans. This measure was done in order to ascertain if there was a significant loss of meaning with the translation process and I remained assured that there were no significant loss (Small et al., 1999).

4.11 Data management

During the informed consent negotiation process participants were asked if the interviews could be digitally audio-recorded for transcription and analysis. The alternative option of making notes during the interview was offered to them as well.

All of the participants gave consent to the digital audio-recording of their interview session. Immediately after the interview the digital audio file was downloaded onto a password-protected drive on my personal computer. Backed-up copies of the audio files were securely saved in case the files became corrupted. The audio files on the recording device were deleted.

After each interview the recording was transcribed within 24 hours. This allowed me to immediately become immersed in the data while the information was still recent, and I could identify the spoken words through the interference of background noise, or unclear speech. The swift, early transcription of recorded interviews is supported by Silverman (2006).

The interviews that were conducted in Afrikaans were also transcribed within the 24-hour timeframe, after which they were sent to the language expert to be translated. The agreed turnaround time between myself and the language expert was 72 hours. The language expert adhered to the agreed turnaround time for the translation of the transcripts.

Transcription was done verbatim in order to construct a semantic record of the interview. Non-conventional words were spelt in a manner which the reader could understand, and significant pauses and emotional outbreaks were noted in the transcript. It is common practice in IPA to transcribe all the words that were spoken by all the parties present in the interview (Smith, 2010).

In order to manage the large volumes of data the software package Atlas.ti 7 assisted in managing data during the analysis process. Atlas.ti could store the transcripts, and allowed me to pinpoint any part of it when needed. It also assisted during the analysis process where electronic links were made between initial notes, emerging themes and connections between themes and cases. An added benefit to the use of Atlas.ti 7 was the fact that all the transcripts could be saved in one software program which could be encrypted. This measure facilitated adequate safekeeping of data.

4.12 Ethical considerations

The ethical principles implemented in this study were guided by aspects of the Declaration of Helsinki (World Medical Association, 2013). Using the Declaration of Helsinki to ensure an ethical research process is the standard in medical research; however, it is specifically written to accommodate quantitative research. In qualitative research the participants are not merely objects being studied, but are true partners in the research process; hence the tailoring of these principles to best ensure the protection of the participants (Pollock, 2012).

Issues of autonomy, non-maleficence, beneficence, confidentiality, justice and compensation were addressed.

4.12.1 Autonomy

In order for participants to make an informed decision to participate in this research study, it was of utmost importance that all their rights and the risks and benefits of participation

were clearly explained to them. Research can only be deemed ethical if competent individuals participate who give their informed consent to participate (World Medical Association, 2013).

I had an individual face-to-face information session with each possible participant. During this session I gave background to the study in order for them to understand the context and scope of the study.

The responsibility of the participant was clearly stated in order to ensure that each knew exactly what her role would be within the study.

It was carefully explained to each participant that they do not have to participate in this study and could withdraw their participation at any time. They would not be disadvantaged in any way for non-participation or withdrawal.

The rights, risks and benefits of this study were stated in the information sheet in a language which they could understand. Each participant could keep the printed information sheet, which had contact details of the researcher, research supervisor and the Human Research Ethics Committee of the University of Cape Town, which they could contact should they have any questions or queries (Appendices A and D).

After informed consent was negotiated with each participant, an informed consent document was signed by the researcher and the participant, indicating that they understood their rights and responsibilities in participating in this study, and did so freely without being coerced. One signed copy was given to the participant and one copy was kept by the researcher.

4.12.2 Non-maleficence

Risks in qualitative research are minimal, and in this study there were no major foreseeable risks for the participants who elected to participate (Pollock, 2012). There was, however, a possibility that participants might experience some emotional distress while sharing their life experiences with the researcher. This risk was explained to each participant during the information session. This minimal risk often occurs in qualitative research studies where in-depth interviews are used as a data collection tool. It is permitted as long as the benefits of the research outweigh the risks, and the researcher put strategies in place to minimise this risk to close to zero (Campbell-Crofts, Field & Fetherstonhaugh, 2013; World Medical Association, 2013).

Through being a registered psychiatric nurse I could easily identify emotional distress occurring during interviews. Should I have observed that the participant was experiencing distress, or the participant herself indicated that she was experiencing distress, the interview would have been halted immediately. Together with the participant we would reflect on the nature of the distress and decide if the interview should continue, be postponed or terminated. A referral for appropriate counselling would be offered, if needed.

All of the interviews that were initiated could be completed. In some of the interviews the participants became emotional when speaking about their experiences. Interviews were stopped and were continued when participants indicated that they were ready to proceed.

One of the participants was referred for appropriate counselling after her interview. This referral was not specifically made because of emotional distress which she experienced from participating in the study, but because she had a longstanding history of depression and needed appropriate counselling and support.

4.12.3 Beneficence

The principle of beneficence is based around the prevention of both physical and emotional harm in participants. In this study various steps were put in place to secure the safety of each participant on both a physical and emotional level, as stated in this chapter.

There were no direct benefits to participants who participated in this study, and it was clearly explained to them and noted in the information sheet (Appendices A and D). However, through the sharing of their experiences of being a transsexual woman, this study gave a voice to an otherwise marginalised community. The interview also gave them an opportunity to reflect on their experiences with a researcher who is truly interested in their well-being. Hennink (2011) and others support this benefit which qualitative research can bring to participants through participating in in-depth interviews.

I explained to the participants that their participation in this study could benefit other transsexual women in future.

4.12.4 Confidentiality and anonymity

The identity of the participants in this study together with the information which they provided were treated as confidential throughout this study, as it is expected from researchers to take every precaution to protect the privacy and confidentiality of participants (World Medical Association, 2013). The following steps were taken to ensure confidentiality and anonymity throughout this study:

1. The consent forms, audio-recordings and transcripts were not stored together. This measure would prevent any links being able to be made between the name on the consent form and the collected data.
2. Each participant was assigned a *nom de plume* directly after the interview and throughout the research report the participant's name real name was never used.
3. The raw data of this study were saved electronically in password-protected files. This password was never shared with anyone and the research supervisor had access to the data upon request.
4. The reporting is done in such a manner that all identifiable aspects in quotes were changed in order to protect the identity of the participants.

4.12.5 Justice

The principle of justice was upheld throughout this study. The justice principle in research refers to the fairness of the study, and the avoidance of exploitation of participants (Orb, Eisenhauer & Wynaden, 2001). In this study the following steps were taken to ensure justice:

1. In recognition of the vulnerability of the research participants, the women were allowed to indicate the safe space in which we met to conduct the research.

2. Participants were allowed to communicate in the language they felt most comfortable in, and were provided with information leaflets and consent forms in the language of their choice.
3. In doing justice to the voice of transsexual women, participants were selected on the basis that they have the best experience to meet the objectives of this research study. They included both rural and urban woman, women of different social classes, races, and educational levels.
4. The time and experience of transsexual women were valued by the researcher and each participant was offered R100 in lieu of her time for participating in this research study.

4.13 Conclusion

This chapter introduced the reader to the chosen methodology which guided this research study, which was also defended against other possible methodologies which could also have been appropriate for this investigation. The argument was made for the superiority of using IPA as a method of investigation. The research process was meticulously described, including the pilot phase of the research, and the steps taken to ensure the ethical soundness of the study were presented.

This will assist the reader to evaluate the science which underpins the analysis of the data as presented in the next chapter.

5.1 Introduction

This chapter demonstrates the analytical process in which data collected through in-depth interviews with ten participants were analysed in order to be presented in a functional manner informing the discussion. The data collection and analysis process occurred concurrently and were initiated in August 2013. While the data collection process was terminated in March 2014, the analysis process continued until June 2014 as cross-case analysis was undertaken after the collection process ended. As in other qualitative methodologies where it is expected that the data collection and analysis process should run concurrently, the IPA theorists insist that this process should be followed (Creswell, 2014; Miles, Huberman & Saldaa, 2014; Hennink, 2011; Bourgeault, Dingwall & De Vries, 2010; Smith, 2010).

Both manual and computer-assisted data analysis strategies were utilised, and the guidelines for analysis of an IPA study as set out by Smith (2010) were used to guide the analysis process. From analysis of the data one superordinate theme, two subordinate themes and nine clusters emerged, which are presented graphically in the next chapter.

5.2 Manual and electronic analysis

With qualitative research data usually take on the form of interviews or focus group discussions which are recorded. These recordings are mostly made useable in the form of transcriptions which are then analysed. It is common for qualitative researchers to do a manual analysis of the transcribed data.

Manual data analysis gives the researcher the benefit of immersing himself in the data through close physical contact with the material he is working with. In larger qualitative studies, however, manual analysis might become difficult to manage as there will be a lot of codes and numerous themes will emerge. The sheer volume of coded data might overwhelm a researcher, and he might find it difficult at later stages to match the data to the code, cluster or theme.

The manual analysis of data can be done in various ways, but mostly a researcher assigns codes to the data, develops clusters, and themes will emerge grounded in the data. This type of analysis is advocated by, among others, Tesch (1990) and Creswell (2014).

With the advent of technology various computer software programs have been developed to assist qualitative researchers with data analysis. These programs are collectively named CAQDAS (computer-assisted qualitative data analysis software), of which the most popular titles in this genre are NVivo and Atlas.ti.

In contrast to manual data analysis, electronic software gives the qualitative researcher the benefit of being in control of his data at all times. He can easily link a code or a theme to the

original text in a mass of data. This software also assists the researcher in building an audit trail in which all decisions the researcher made at specific times are saved electronically (García-Horta & Guerra-Ramos, 2009; Carvajal, 2002). Even though the benefits of electronic data analysis are well described in the literature, using CAQDAS software to analyse qualitative data is often critiqued by qualitative researchers and even rejected by some as a rigorous scientific manner for qualitative data analysis.

The critique on electronic data analysis often given by researchers opposing this method is the fact that researchers do not have enough contact with the data in order to really become immersed in it. They also strongly reject the use of the auto-coding capabilities of these software programs, which allows the researcher to program codes in a code-bank and the program will automatically scan the data and assign codes to the text.

In this study ten interviews were conducted, and on average each interview transcribed yielded 10 000 words. This constituted a large volume of data which had to be analysed. I was initially interested in utilising CAQDAS software to assist with analysis of the data of this study, and I received training in the use of Atlas.ti from an accredited Atlas.ti trainer. However, after mastering the program it became clear to me that electronically assisted analysis on its own would not be sufficient for analysis of the data in this study. I utilised the strengths of both manual and electronic qualitative data analysis strategies to analyse the data of this study.

Initially I used Atlas.ti to store the transcribed interviews. The programme automatically generated a unique document name. During the initial noting phase of the data analysis, I could assign descriptive, conceptual and linguistic comments electronically on the document within the software program. The benefit of doing this step electronically lay in the fact that immediate links were made between the data and the comments. On completion of the initial noting a printout was made with the comments connected to the data. I used this printed version to manually develop emergent themes. Complementing the manual process, I made electronic links between the comments and the themes within the software program. The same process was followed to search for connections across themes and patterns across cases.

The use of electronic means to analyse the data of this study proved to benefit this study in the following ways:

- Data were securely stored with a unique identification which could be easily located.
- Initial noting could be done within the program, which gave a convenient view of the data, the comments and clear links made between the two.
- User-friendly documents with accurate references to exact location of the data could be printed, which complemented the manual phase of the analysis.
- Connections could be easily made between comments and themes within a transcript and across transcripts.
- The software could generate user-friendly graphics to explain the data and connections in the data.
- Throughout the process, order within a large data bank could be upheld.

Complementing electronic data analysis strategies with manual analysis strategies provided the following benefits for this study:

- The manual process in the data analysis allowed me time to become immersed in the data.
- The fact that I could physically see comments or themes pasted against a wall for extended periods of time allowed me to make the connections within this data and to allow emergence of the interpretation in an organic manner.

In triangulating two strategies in data analysis, some negative aspects of both these strategies came to the fore:

- The programme is programmed to assist the researcher to assign codes, clusters and themes. The steps in IPA analysis differ slightly, and I had to make changes within the program to become aligned with the IPA manner of data analysis.
- It became quite time-consuming to make the electronic links within the software after the manual analysis was done.

This process of utilising the best of both manual and electronic-assisted analysis strategies proved to be beneficial for this study. In the following part of this chapter I will explain in detail how the analysis was performed according to the steps for IPA analysis, with the aid of electronic and manual data analysis strategies.

5.3 Steps in analysis

The aim of IPA analysis is to move descriptive narrative into the interpretative domain through making sense of the experiences of participants (Reid, Flowers & Larkin, 2005).

This was achieved through implementing the following six steps (Smith, 2010):

1. Reading and rereading
2. Initial noting
3. Developing emergent themes
4. Searching for connections across themes
5. Moving to the next case
6. Looking for patterns across cases.

5.3.1 Reading and rereading

Through the reading and rereading of the collected data I had the opportunity to immerse myself fully in the data.

After the conclusion of an interview I downloaded the audio-recording onto the secured drive on my computer and listened to the recording. During the second, slowed-down replay of the audio-recording I proceeded to transcribe the recording myself.

The printed transcript was read as a whole while I yet again listened to the recording. This step was used to compare the accuracy of the transcript with the recording, and it gave me another opportunity to not only listen to the words spoken by the participant but to get a sense of the emotion in the voice of the participant.

The following day I would set time aside to again read the complete transcript. During this time I refrained from interpreting the data and would stop immediately should any of my preconceived ideas started to cloud my thoughts. I would re-engage with the transcript with a clear mind and complete it ending with a holistic view of the content of the interview.

At the end of this phase I engaged at least four times with the material as a unit. I ended up with an all-inclusive view of exactly what happened during the interview and gained a broad understanding of the experience of the participant.

5.3.2 Initial noting

After becoming immersed into the world of the participant by reading and rereading the transcript, I started the process of initial noting. Descriptive, linguistic and conceptual comments were made on short pieces of text in the transcript.

Descriptive comments were mostly made in describing the participant's experience. Many of the descriptive commentary made could be described as *in vivo* codes where the exact words of the participant were sometimes used to describe the experience.

Transsexual women use a specific jargon when they speak about themselves and their experiences. During interviews they would become emotional and sometimes even cry or laugh inappropriately when they spoke about traumatic or extremely personal events. They would also repeat words a couple of times in order to stress the importance or trauma of an event. All of these were noted as linguistic comments.

Conceptual comments were often made in the form of questions which were asked by the participant. This questioning assisted the researcher to sometimes reflect on what was not said by the participant and allowed him to start to 'read between the lines' as to what was said by the participant. Most of the conceptual questions noted by the researcher were answered through the linguistic and descriptive comments made. Conceptual commentary was also the first step in shifting the data from a mere descriptive level towards interpretation, while still remaining true to the data presented.

In the first round of the initial noting process most of the comments made were of a descriptive nature. I returned to the transcript while taking a fresh look at the text, and with time more conceptual commentary emerged.

The comments made to the ten transcripts totalled 657. Below is an example of how comments were made against an extract of a transcript. This procedure was followed with every transcribed interview.

Table 5.1. How comments were made against the transcriptions of the interviews.

Original transcript	Comments
<p>H: OK, hmm, there are many things that happened since I started with the hormone treatment. Point number one is, good things have happened to me is that I can really feel breast development happening, hmm, I can feel my facial hair is softer, I don't need to shave as often now. Those are the positives for me. Although the medication is still on a small ... really small version still. What happened is, hmm, after I started with the treatment and tests that were done on me, they discovered that it impaired my liver. I had to go to Hospital X to the liver clinic for a few weeks, and the doctor at the liver clinic told me that I have hepatitis B. They put me on treatment for that, and what I don't understand is that hepatitis B impaired my liver and my liver is impaired because of the hormone treatment. Why I say because of the hormones, I am very health conscious. If I get a light cold, then I go to the doctor. Even though the doctor thinks I'm oversensitive. I have never experienced such things in my life, and what makes it sad for me, is that I feel if the doctor..., I still go for treatment, because if I understand the doctor correctly, look I don't have a medical background, the medication that they give, is the same medication that people who are HIV positive gets. So I'm on ARVs now. Like someone with AIDS. And it's medication that I have to use for the rest of my life because of hepatitis B.</p> <p>The reason why I still feel emotional about the orchidectomy [surgical removal of the testicles]. I felt that if the orchidectomy was done, or will be done, then I have, then I have, my body does not produce as much male hormones, which means my health will improve. And with this I want to say that the medication that the doctor prescribes to me can be less, because then the oestrogen in my body is so much stronger, and I don't need more medication which puts my health at risk. There are many other things also, I also talked about it the other day at the office, because a lot has happened to me that actually never (before) happened to me. I started getting a skin rash when it's hot, and then I have pimples and things that pop out on my face, and if I can show my feet ... Such things happen to my feet. Everything started after I began to use the medicine. I got such rashes. Can you see?</p>	<p>First comment about medication is the positive changes experienced. (Conceptual)</p> <p>Liver damage from using hormone replacement therapy (Side-effect). (Descriptive)</p> <p>She is taking antiretrovirals (ARVs) to manage her liver damage. (Descriptive)</p> <p>She understands that the liver damage is caused by the hormones. (Descriptive)</p> <p>Stutters when she speaks about operation. (Linguistic)</p> <p>Urgent need to have surgery as this will decrease the need to use hormones. (Descriptive)</p> <p>She is distressed about the body image resulting from hormone replacement. (Conceptual)</p> <p>Skin rashes occurred after commencement of treatment. (Descriptive)</p> <p>Healthcare for transsexual women is a favour and they must be patient. (Descriptive)</p> <p>Uses the word 'very' twice to accentuate the long waiting list for surgery. (Linguistic)</p>

<p>I really feel if they can give me the operation, that my body don't produce any more male hormones, with the result that I get place on weaker pills, because I must have hormones in my body, then these things can be controlled. Yes, I understand that the list at GSH is very very long and I understand they don't have much time for transgendered people in the theatre, but I feel this, that it isn't something of importance for them. It is just as if they do us a favour and so on, and I feel it's very unfair against us as transgendered people.</p> <p>D: Harriet, you talked about your liver just now, you skin ... is there any other things that happened with your health. I hear that you are very conscious about your health.</p> <p>H: I don't think there are other things that I've picked up on. This is what I experienced. The hepatitis B and it is very serious, I don't accept the doctor's explanations about why I have hepatitis B. They say it has to do with my growing up years, and my liver just waited for something to let it come out. It could've been water, it could have been where I played, but I'm not satisfied with their explanations. They don't open up to me!</p> <p>D: Harriet, I know you go to the doctor for the liver and so and they monitor it, but for the skin rash and such things, what do you do about the problem?</p> <p>H: For the skin rash in my face I just put on some ointment I get at the pharmacy. For my feet I buy an ointment for ... I can't remember so clearly now the ointment, but I think it is for people that have diabetes. It's a tube of ointment that is at the pharmacy, and the first time I used the ointment, it worked very well, and the other time it became to work weaker and weaker on my skin. So much so that the sister advised me to not wash myself with just any other soap, but to use only green sunlight soap. So this is the only thing I do at the moment.</p>	<p>Doctors are not honest in their explanation of side-effects. (Descriptive)</p> <p>Uninformed, unsupervised self-care for side-effects. (Descriptive)</p> <p>Why does she not ask the care provider for assistance with the 'minor' side effects? (Conceptual)</p>
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5.3.3 Developing emergent themes

In developing emergent themes connections, patterns and interrelationships are formed between the comments made against the transcripts. It also allowed me as the researcher to

reduce the volume of data while the essence of the phenomenon remains. These emergent themes will reflect both my interpretation and will crystallise the voice of the participant.

The process was started by printing all the comments made on a particular transcript. The printed comments were put in the form of flashcards and were pasted randomly on a wall.

I viewed at the comments on the wall, and started to look for connections between them. The comments were grouped in a logical order and the grouped comments were assigned a theme name. This was quite a time-consuming process, as the connections were not always obvious. It was also of utmost importance that I had to do justice to the participant's voice while naming an emergent theme. Many times the comments would be posted against my study wall for a couple of days before themes emerged.

The themes depict a synergy between the participant's description and my interpretation of the phenomenon.

Below is an example of an emerging theme developed from the transcript of Caroline. Caroline described the difficulty she has to find appropriate information to manage her health since she was initiated on feminising hormones. She is of the opinion that doctors will only give information to her on a 'need to know' basis, and when they do provide information it is deemed superficial. Her main sources of information are her transsexual friends, who themselves have limited knowledge. Being ill-equipped with accurate knowledge about her health and realignment process leaves her feeling disempowered.

The theme which emerged was 'Information Throttle', as the description made it clear that there are people who hold the power over knowledge transfer (Figure 5.1).

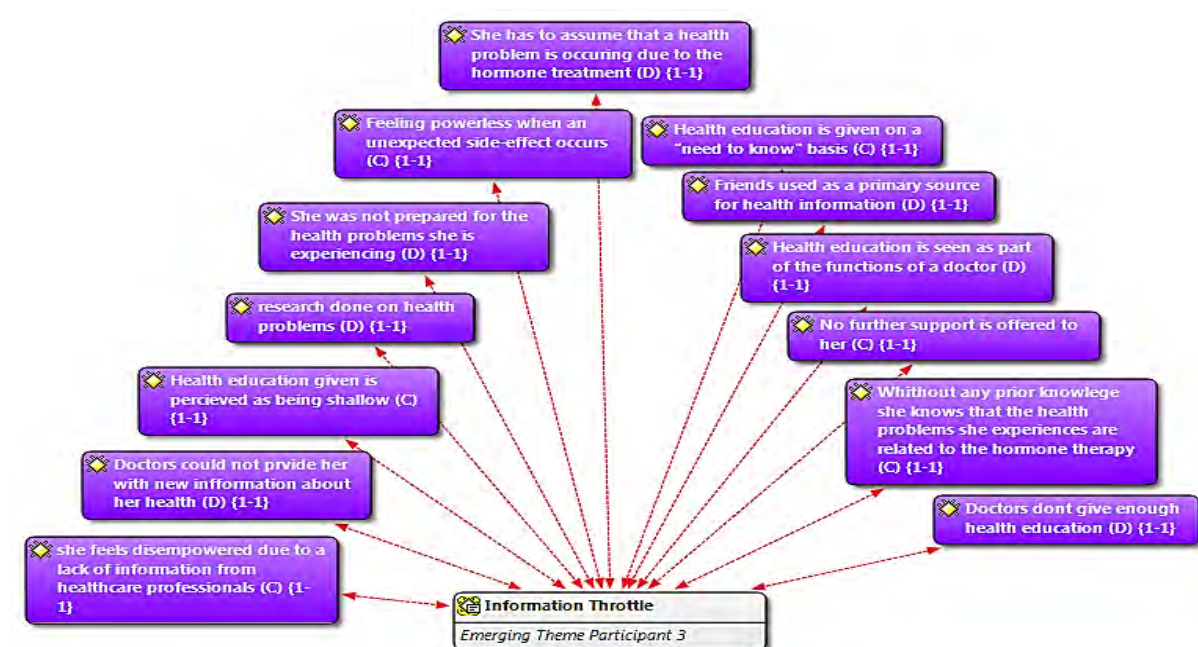


Figure 5.1. Development of an emerging theme.

5.3.4 Searching for connections across emergent themes

During this step of analysis connections between the emergent themes were established. I branded them as connected themes. These connected themes attempted to capture synergy between emergent themes, and would assist with making connections across cases in later analysis.

Revisiting Caroline's case, five of the emergent themes formulated in her transcript could be clustered together to form one connected theme. The emergent themes which were clustered together were mainly about her interaction with the healthcare system, the healthcare providers and the care which she receives as a transsexual woman.

The connected theme 'Realities of care' emerged, which contributed to satisfying objectives two and three of the study.

Figure 5.2 illustrates the emergence of the connected theme with the connections right down to the initial noting phase.

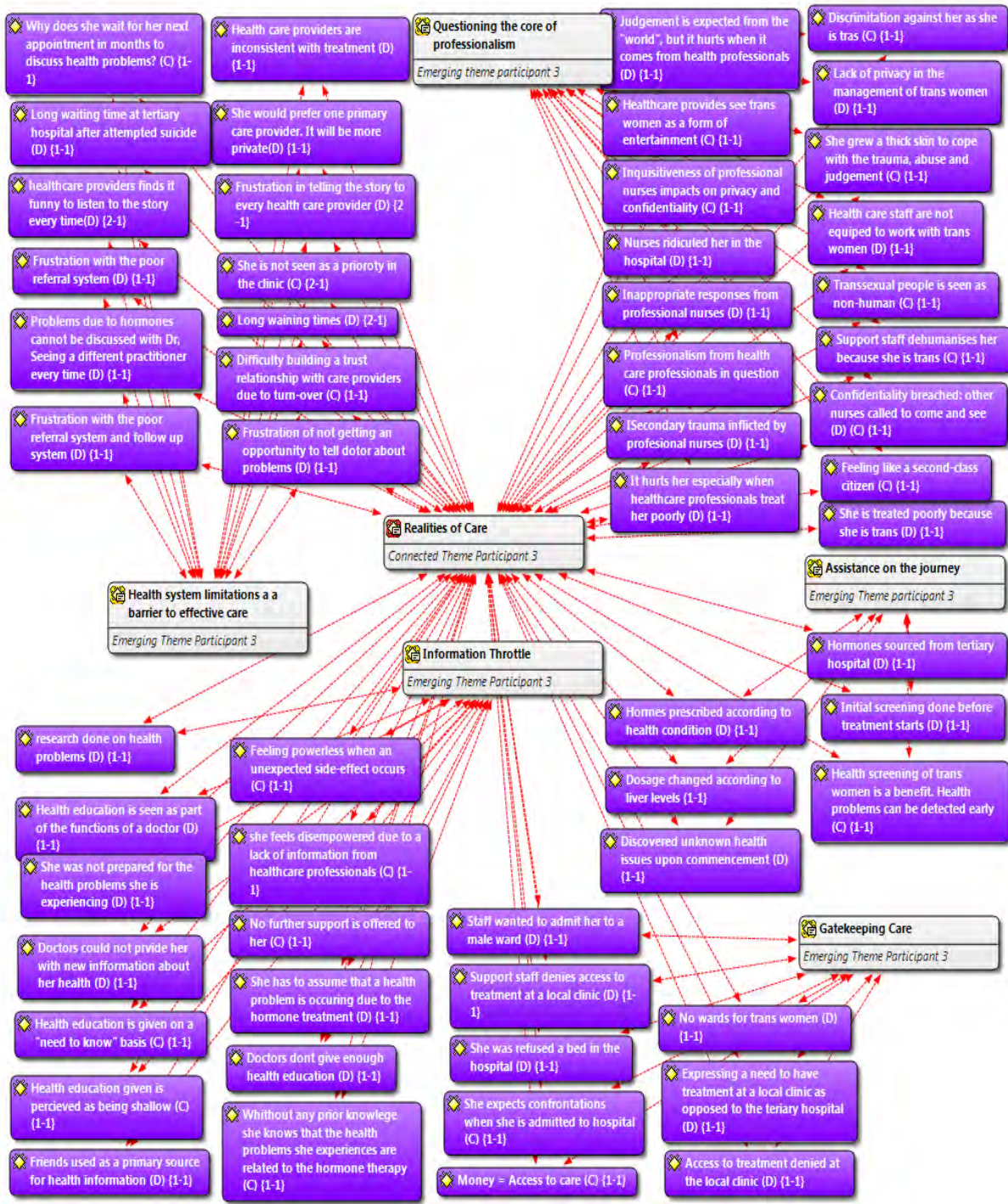


Figure 5.2. Emergence of a connected theme with the connections right down to the initial noting phase.

5.3.5 Moving to the next case

The data collection and analysis process of this study were executed concurrently. Before I moved on to the next interview, the transcription and analysis of the current case had to be completed.

Bracketing is an attempt to prevent the researcher from missing new information due to making premature connections between the current and previous interview (Tufford & Newman, 2012). In moving on to the next case, I attempted to park my preconceived ideas which I gained through experience, the literature review and the previous interview, to prevent them from influencing my analysis of the next interview experience. I approached the following interview as naïvely as possible. Constant alerts were made whenever I realised influence from the previous interview and analysis experience was creeping in.

5.3.6 Looking for patterns across cases

In IPA research the final stage of data analysis is termed 'looking for patterns across cases'. This stage in the data analysis can be closely compared to the more common practice in qualitative case-based research of 'cross-case analysis' or 'comparative analysis'. Cross-case connections were made through looking at the similarities and differences in the analysed data of the ten heterogeneous participants sampled into this study. By performing this step in the analysis process it enhanced the transferability of the findings of this study to other African contexts in which transsexual women find themselves, and added to a more in-depth understanding of the collective experience of ten transsexual women (Miles, Huberman & Saldaa, 2014; Yin, 2011; Bourgeault, Dingwall & De Vries, 2010).

After all the interviews were analysed individually, the final step in the analysis process was to start searching for patterns across cases. This process shifts the analysis to a more theoretical level whereby super-, and subordinate themes emerge which represent the broader sample instead of only the individual.

This process was done through printing all the connected themes with their associated emergent themes. As was done initially with the emerging themes, flashcards were made and pasted on a large wall.

This time-consuming yet rewarding process required me to move between the various connected and emerging themes, right down to the initial comments and transcript quotations, to find cross-case connections. The use of Atlas.ti 7 was invaluable at this stage, as electronic connections were made during the analysis process and I could easily find every word in the massive data bank at the touch of a button. Having such an ease of access to the information, I could spend all my time making such connections and interpreting findings rather than searching for the information.

In IPA research what is called a master table of themes will usually emerge from this process. Initially I developed a master table of themes, but I was not confident that the table necessarily did justice to the study. After long discussion between myself and my research

supervisor, it became clear that a master table of themes would be too linear and failed to demonstrate the interconnectedness which emerged in the analysis process.

A graphic was developed in order to illustrate the 'master table of themes', with the interconnections. I called it the 'master theme graphic'. The master theme graphic is constructed with one superordinate theme, two sub-ordinate themes and nine clusters, and is presented and discussed in the following chapter.

5.4 Conclusion

Within this chapter I introduced the reader to the data analysis strategy which is used by the theorist who developed IPA. I also explained in detail the strengths and deficits of using manual and electronic data analysis strategies. I reported on how I harnessed the strengths of both manual and electronic data analysis strategies to manage and analyse the data collected through ten in-depth interviews.

This clarity with regard to the strategies which were implemented to analyse the data will not only furnish the reader of this report with a thorough audit trail, but will assist the reader to gain a clear insight into the findings as presented in the following chapter.

6.1 Introduction

This chapter describes the key findings from this study which investigated the life-world of transsexual women in relation to their awareness of their unique health needs that occur as a direct result of their sexual realignment treatment, and their health-seeking behaviours, practices and experiences of responses in negotiating health care for their transgender-related health needs in the healthcare system.

Ten participants formed the sample in this study, which I will describe below. The analysed data gathered through in-depth interviews yielded one superordinate theme, 'Towards organic womanhood', and two subordinate themes labelled 'Embracing womanhood' and 'Facing the giant in order to become'. Due to the interconnectedness of the themes and clusters it was impossible to present the themes in a table; hence a double helix is used to graphically represent the interconnectedness of the themes and clusters (see Figure 6.1).

The first theme, 'Embracing Womanhood', relates directly to the personal journey of transsexual women when they are utilising the treatment package of feminising hormones and surgical sexual realignment. This theme is constructed out of five clusters. The first cluster in this theme presents 'Giving freedom to the woman inside'. It gives insight into the freedom transsexual women experience as soon as their physical embodiment starts to change and they are free from the entrapment of existing in a body which is incongruent to their gender identity. 'Sexuality' is the second cluster, in which the differences and connections between gender identity, sexual orientation and sexual practice are presented. 'Living with side-effects' and 'Mental wellness' provide the reader with insight into the experiences of physical and psychological side-effects which transsexual women face on their journey. The last cluster, 'Surgery', depicts the need transsexual women have to become complete as woman with the aid of surgery.

The second subordinate theme is entitled 'Facing the giant in order to become'. The giant which transsexual women have to face in their quest to become complete would include the healthcare system and the healthcare practitioners who are the gatekeepers in this relationship between the transsexual woman and 'Organic womanhood'. This relationship is described as a relationship of dependence and power imbalance.

From the four clusters which construct this theme, 'Practitioners' gives insight into the relationship which exists between transsexual women and healthcare practitioners. 'Being kept in the dark' sheds light on information sharing between healthcare providers and transsexual women. The cluster labelled 'Care' gives insight into the experience women have when they receive care in the healthcare system, while 'Access denied' illustrates how access to transsexual healthcare services is denied to transsexual women on various levels.

In order for transsexual women to become free from the entrapment of their male embodiment, they need assistance from healthcare providers and the healthcare system. The

treatment they receive assists them with realigning their gender identity with their physical embodiment. This treatment could make them vulnerable to various side-effects, for which they would have to negotiate care yet again from the healthcare system. This complex relationship is graphically illustrated in Figure 6.1 This relationship is ongoing as long as transsexual women are striving 'Towards organic womanhood', which is the superordinate theme identified in this study.

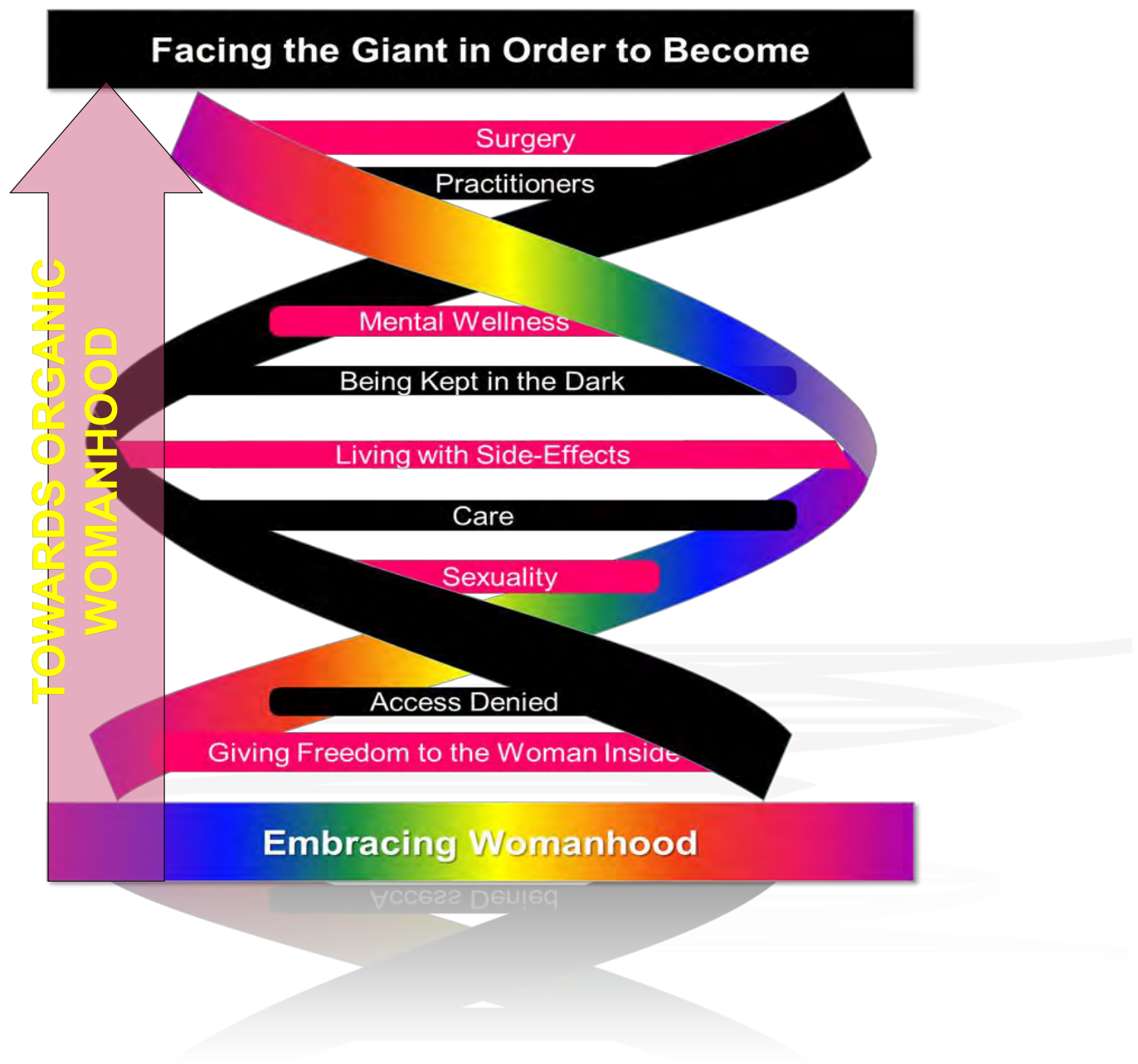


Figure 6.1. Superordinate theme, subordinate themes and clusters which emerged from the data in this study.

6.2 Introducing the participants

In this chapter care has been taken to give a voice to each of the participants. In an effort to further assist the reader to become familiar with the context and circumstances of each participant mentioned in the study, a concise description of each is given below. Their real names are not used in order to protect their identity.

Allison is a 40-year-old woman who has been in transition for 15 years. She is a qualified healthcare professional practising in a rural area. She utilises the private healthcare system for her trans-related health care. Having had an orchidectomy, Allison plans on having complete surgical sexual realignment. Funding is preventing her from taking this step. Although she has medical insurance, they are not willing to fund her surgery completely. She is in negotiation with the medical insurance for assistance with this regard.

Allison is a strong woman who has survived transphobic violence, managed depression and experienced marginalisation as a transsexual healthcare professional. Yet she has excelled in her professional life while making a positive contribution to her community.

Brenda is 27 years old and holds a university diploma. She finds temporary employment in the informal sector. Her home is on the Cape Flats and she utilises the public healthcare system for her care.

Brenda comes across as a very shy woman who lives a private life. She struggles to find acceptance in a community where gangsterism and violence are the norm. Being pre-surgery, she finds it difficult to negotiate heterosexual relationships with men and this leaves her with feelings of loneliness.

Caroline is 30 years old, holds a school leaving certificate and works permanently as a hairdresser. Like Brenda she is also from the Cape Flats and makes use of public healthcare.

In contrast to Brenda, Caroline is extremely self-assured. She is engaged to her heterosexual male partner who provides her with the necessary emotional support. Feminising hormones have assisted her greatly with her physical transition. She has however also suffered depression, and made a suicide attempt six months after the initiation of treatment.

Diane is 28 years old, holds a school leaving certificate and works as a shop assistant in a rural area. Diane has no access to trans health care and uses hormones off-code to assist her with her transitioning process.

Diane came across as being naive. Because she has no information whatsoever on how feminising hormones work, she merely takes her treatment blindly with the hope that nothing serious happens to her body. Her heterosexual male intimate partner wants Diane

to be surgically sexually realigned, but they have no information of how and where to seek care.

Ester is a 50-year-old woman who has been in transition for 32 years and has had both top and bottom surgery completed. She is the owner of a hair salon in a rural town and travels to the city to receive her trans-related healthcare treatment at a public hospital.

Ester has suffered major side-effects from the use of feminising hormones and surgery throughout her journey. She suffers chronic depression and self-medicates with alcohol and drugs.

Francis is a 48-year-old home executive from a peri-urban middle-class suburb who utilises the public healthcare system.

She expresses the freedom that she gained from being initiated on feminising hormones, after she was denied care more than 22 years ago. She completely embraces womanhood by taking on all the heteronormative female roles. She is in a stable long-term relationship with a homosexual man and is privileged to have a strong support network.

Glenda is also in her fifties. She qualified as an electrical engineer, but due to her ill-health was declared medically unfit to work. She used to make use of the private healthcare system, but currently is also in the public healthcare system.

While dealing with cancer and depression, Glenda continues to be an activist for the rights of transsexual women. She is featured regularly in the print and television media as an activist.

Harriet is a 36-year-old woman who utilises public healthcare. She holds various diplomas and works at a local NGO.

Harriet is suffering chronic side-effects from using feminising hormones. She is upset with healthcare providers and the healthcare system for not treating and monitoring the health of transsexual women appropriately.

Imelda is 32 years old and is studying towards a university diploma. She currently works as a part-time restaurant manager close to the peri-urban township where she resides. She travels to the city to receive her trans-related health care from a public hospital.

Imelda cannot wait to start her professional life after she completes her studies. She has the dream of being a complete woman when she enters the professional world. Imelda has also been the victim of a hate-rape and secondary victimisation by the healthcare and judicial system. She suffered the trauma of rape, but uses her experience to support other women who suffer violation.

Janet is a 70-year-old semi-retired woman who resides in one of the affluent suburbs of Cape Town. She has been in transition for 42 years and receives her care from the public healthcare system.

Janet has lived a satisfying life as a woman and is ever so grateful for the opportunity, which she had in the 1970s, to have her complete surgical sexual realignment completed.

6.3 Subordinate theme 1: Embracing womanhood

This subordinate theme captures the lived experiences transsexual women have when they are on the journey of sexual realignment. The clusters presented in this theme are:

- Giving freedom to the woman inside
- Sexuality
- Living with side-effects
- Mental wellness
- Surgery.

6.3.1 Giving freedom to the woman inside

A body incongruent with their gender identity leaves transsexual women trapped. There is a woman on the inside, yet she is living in the body of a man.

The treatment package of feminising hormones and surgical sexual realignment can free transsexual women from the shackles of male embodiment. The treatment is described as liberating and life-changing.

Francis: "Do you know what, I don't regret it one day. This is the most wonderful thing, and every time I say I wish it was earlier in my life. Now I grab every opportunity. I'm like a drug addict at the moment. I just want to buy. I just want make-up and my clothes and shoes. I just can't stop, because I missed so much as a woman, in my years after I had done it. I am ... this is just the most wonderful thing."

"I don't regret it that I started it. My breasts are starting to develop. My face changed a lot, my body, everything. It is absolute. I wish I could have done it earlier in my life, but unfortunately I discovered it later that one can have it done, but I don't regret it. I still have quite a few years ahead of me to be who and what I want to be as a woman."

The objective of using feminising hormones is purely to facilitate the development of secondary female sexual characteristics, yet the women confirmed that it makes them feel more "woman", more organic. This feeling of alignment was the first response of each participant in the study, even though the first question was on how their health changed since they started hormone therapy.

Allison: "Physical changes and mentally I am still the same person from childhood. My state of mind is still my own thinking, but physical it is definitely hormones that makes your breast grow and makes you a little rounder on your body. I was never really very muscular, but I can see more rounding

that's visible and you just feel then, you feel just more, how can I say, hmm, in contact with yourself that I'm more woman. I don't know if I put it clearly, but this is the feeling I get."

Caroline: *"I started my hormone treatment, and after I have seen changes on my body and stuff like that and, having have identified as a woman most of my life, I felt more like one in that moment in time cause there is certain stuff that I could see. Physical changes.*

"I was born a male ... due to the fact that I have got a penis. That's why there was written male on my birth certificate. If there was a vagina they would have written female. You catch my drift, I mean, certain aspects that define who you are supposed to be."

This feeling of being a woman manifests so strongly that some transsexual women experience menstruation-like symptoms.

Brenda: *"What I can say is that once a month ... uhmm ... There are some kind of symptoms, but it is not too ... uuuh, it doesn't make me uncomfortable. The itching of the breasts and the painful nipples. I would have this itch in my legs as well and the doctor explained to me that certain periods of the months when females get their cycle ... uhmm, their hormones are elevated. I'm not exactly sure what the reasons are, but some time of the month I do experience some symptoms. After speaking to other females ... uhmm ... are very similar to what they go through during their cycle, uhm, that would be the only sort of side-effects that I can think of."*

Allison: *"As in mood hmm levels was not always as it should be and sometimes I was very, let's say now teary at the beginning or I was just very ... almost like one who would like a women now will, let's say, menstruate, then the mood would be a little off. It fluctuates in one day's time up and down in her on her life."*

Reflecting on the life of entrapment prior to surgery, the women explained a feeling of disharmony between their bodies and gender identities. This clearly comes to light in the discussion of Brenda, when she says that after the commencement of hormone therapy her stress levels came down, she has better control over her emotions, and it has even assisted her with critical thinking.

Brenda: *"Before hormone replacement therapy, umm there were two sides to me. There was a side that I felt comfortable with only showing certain people ... my true self. And another one that was sort of a front you know, that I put up for the rest of the community, especially my family and friends. Uhmm, but to me yes, that was the biggest sort of influence that hormone replacement therapy gave to me.*

"... besides the subtle changes was that mentally it benefitted me quite well. I was a more stable person. Umm I, before I used to be indecisive, right now I am you know very present. And I am able to make very critical decisions, especially where my body is concerned, umm and my identity is changed.

"I have started hormone replacement therapy. Three to six months in, I started to become more calmer, if I could explain it that way and umm less stressed."

Looking at two cases in particular, Imelda is pre-surgery and she is extremely anxious to have her body realigned to her gender identity. She is on the brink of entering the professional world and wishes to start her career as a complete woman. She is of the opinion that her incongruent physical embodiment is placing her life on hold:

Imelda: *"I asked him that I need to finish this. I am going to start working soon. I want to go into the work environment as a complete woman. I don't want people to look at me and then everyone is saying afterwards: 'She was a man!' I want to walk in there as a complete woman.*

"I did not get that from them. It's almost like they are making this process such a ... I heard from a friend that it is going to take ten years. For me to wait ten years ... My life is over. I need to start now, to be successful."

In contrast to Imelda, Janet completed her surgical transition more than 40 years ago. She is comfortable in her skin and feels that being a woman is about living a decent, functional life, and the opportunity she had to align her embodiment with her gender identity made her free:

Janet: *"I mean people have normal lives, decent, respectable, normal lives, and that is what it is all about. It is not about flaunting yourself out there. That is the thing and that is what I am so against. People flaunting themselves. They have no morals whatsoever."*

Douglas: *"It's not a show."*

Janet: *"It's not a show, it's a life. Get on with it and live it decently and respectably.*

"That is right, Douglas. I can live my life freely. I am extremely happy, extremely happy, yes. I have a wonderful career. I worked in beautiful places, marvellous places. I am always called upon to do things. I am called in to teach because of what I did with my life through the years. And I mean that there is still more that I think I can do. I just don't want to sit and stagnate en wag vir die engele [wait for the angels]."

Being free for a transsexual woman entails that she would need to have her physical embodiment aligned to her gender identity in order to live a functional life. This process could essentially be quite easily facilitated through access to transsexual health services. Most

of the women in this study were still pre-surgery and have a body which is halfway in the making.

Looking different leaves these women vulnerable to the judgement of society. They are constantly judged and may sometimes feel that they have less worth than a woman:

Esther: "Some people accept you, some people don't. People skinner [Afrikaans word for gossip], they talk, they bring you down. They bring you down to the dust of the earth. They think nothing of you.

"... because if I walk into a room then you think they just giggle or spoke about you. Or than it felt like I struggle to get up and that I don't feel like work. They send you in the direction of depression, but as I say I'm a very strong person, but even if you are strong, you get to a breaking point."

Allison: "You understand, and, hmm, then you feel hurt and try not to show it on your face, and you feel you are so thick-skinned. You have put on the thick skin and it is water off a duck's back, but you feel it and it still hurts. You don't show it to them. You hear it so often that they don't address you as you would like to be addressed, or respect you, they still try to say you were born this way and I will approach you like that.

"... but you as the transsexual are hmm are constantly hated, to say it in that way. Do you have to dress like a woman every day? Must you be like a woman every day, and what makes it so bad is because your anatomy is now a man's, hey, and society just cannot understand it, can't grasp it, because a woman is better than a transsexual. Do you understand what I mean?"

All transsexual women want is to be seen as human beings with value:

Allison: "You are firstly a human being before you are a man or a woman or before you are black or white. So firstly see me as a human being before you can judge me as transsexual or moffie [derogatory label used for a gay person] or whatever name they want to call me."

6.3.2 Sexuality

As discussed earlier in this thesis, clear distinctions are made between gender identity, sexual orientation and sexual practice. Although these three aspects of sexuality should be seen separately, all three of them will come into play in some form or the other in every human being.

Transsexual women self-identify as female. Their sexuality could either be heterosexual or homosexual. All of the participants in this study identified as heterosexual females. A heterosexual transsexual woman pre-surgery will have difficulty in expressing her sexuality and finding a heterosexual man who understands her world and is willing to enter into an intimate relationship. This often leaves transsexual women lonely and sad, as articulated by Brenda.

Brenda: *"Ok, uhmm, in my case I have had many, many experience where I have been out wherever in a mall or a club or movies when I would encounter men and they would approach me. Obviously thinking I am a biological female, uhmm and you know sort of flirting and like asking do you want to go on a date or can I see you afterwards. I don't know to me that is such [laughter], it's kind of traumatising cause [they] are standing and sometimes you like this person and you think to yourself, I am not going through this process of explaining that I am transgender, which is kind of a difficult thing for me. So I have not been dating in a while, cause I haven't been able to manage, I don't know, be comfortable with that sort of process of telling someone 'Listen I am a trans woman'. And you don't know what to expect from that. You are afraid of being outed. People in my immediate surroundings obviously know, but it is becoming harder and harder to pinpoint that I have had a sex change and those circumstances, I kind of find very difficult to relate to. The kind of uncomfortability, speaking to a stranger who doesn't know, and in my mind I'm thinking 'Does this person know?'. You almost become paranoid. And you know that type of, I think they could offer more emotional support where that is concerned. How to cope with those situations, cause it happens quite often."*

Negotiating heterosexual relationships might even be dangerous for transsexual women. They stand the chance of experiencing violence should they be "discovered".

Allison: *"... So I have been in cases where I hmmm could have gotten hurt, as I say I only mention it for interest's sake. I could have gotten hurt, where I took chances to go with someone to his place, and where the man tied me up and told me, but tonight he make an example of me. And as in ... he wants to slit my throat."*

Some transsexual women are in homosexual relationships prior to their transition. During transition such relationships might take strain due to the fact that a heterosexual woman will be in a relationship with a homosexual man, as in the case of Francis.

Francis: *"I explained to him and he knew who and what I am. He didn't have a problem with it. We then went on all the years as a gay couple, till one day three years ago. I walked on the beach, I was extremely negative. I didn't want to go on. I felt that I didn't want to live anymore. Why am I living? I spoke to the Lord."*

"Pappa is gay. It's very difficult but it's very, very difficult for me because I have that need as a woman, who you are and what you need and that I can't get. That I could get from the other person. This is probably why I fell in love with the other guy."

"But still I love my partner very much. I would never ever get someone like him. Never ever. There is no person like him [Sighs]."

This is confirmation that gender identity, sexual orientation and sexual practice should indeed be viewed as separate entities, and people will compromise in various manners when it comes to having intimate relationships.

In this instance the health care service could be of assistance with the facilitation process of sexual realignment of transsexual women. After sexual realignment it would be easier and safer for transsexual women to negotiate intimate relationships being heterosexual, homosexual or pansexual.

6.3.3 Living with side-effects

Realigning the physical embodiment of transsexual women to their inner gender identity is not without risk. Medical literature clearly demonstrates the risk of introducing feminising hormones to a male body and the impact of surgery. The side-effects transsexual women experience can be divided into minor, major and surgical side-effects.

Some of the minor side-effects experienced discussed by Caroline and Harriet are hot flushes, skin problems and general malaise:

Caroline: "... a few stuff has changed like the fact that I get tired very easily, I'm not as active as I used to be. Just a small walk up here [laughter] was 'uitputtend' [exhausting], and ja, basically the hot flushes. OOOh that is terrible, I dread the summer coming on [laughter], and ja, that is basically it. That is the only health issues I have."

Douglas: "Hmm: tell me."

Caroline: "A few skin problems."

Harriet: "I started getting a skin rash when it's hot, and then I have pimples and things that pop out on my face, and if I can show my feet ... Such things happen to my feet. Everything started after I began to use the medicine. I got such rashes. Can you see?"

From a medical perspective these side-effects might be seen as minor, yet they can have a great impact on the social and occupational functioning of transsexual women:

Caroline: "That tiredness is extremely exhausting. I used to, I used to be a very active person. I could start weekends ... it's from Friday to Sunday supposedly, but mine started Wednesday [laughter]. But I can't do that anymore. I find myself being extremely tired. Especially during the week, and nowadays I don't even do that much on weekends anymore, but the little that I do, It feels like I did, you know, a few months' work. And like evens, I'm not even into clubbing anymore that much. I used to be mad about the dance floor, just to jazz. I can't even spend 20 seconds on the floor and then I am so tired. It's really ... That's the only issue I actually have."

Douglas: "And does the tiredness influence your work performance?"

Caroline: "Yes, it's like now I will have two or three clients and then I have to take a break. You know, whereas before I would have started to work at 9 and work straight through until lunch time and then take a break unless there is no clients, but I can't do that anymore. And I have to go to the loo just to go wash my face cause I am sweating continuously."

Sexual dysfunction was also reported as a side-effect of treatment:

Diane: "Well ... How do I put it now [laughs], that, the feel when one gets horny and so, for instance. That went down a little, so I'm not in the mood for ... that, let me say sex, not for sex [sighs]. How do say now, to be active with someone."

Douglas: "Ok, and tell me what else changed?"

Diane: "Well, I think my, my private parts, does not stand up so much. But it's probably part of the dead, the feeling of death."

Some of the more serious complications of the use of feminising hormones which were uncovered in this study are hepatitis B, stroke and cancer.

Harriet was diagnosed with hepatitis B and is currently on life-long ARV treatment to manage her liver disease:

Harriet: "What happened is, hmm, after I started with the treatment and tests that were done on me, they discovered that it impaired my liver. I had to go to Hospital A to the liver clinic for a few weeks, and the doctor at the liver clinic told me that I have hepatitis B. They put me on treatment for that, and what I don't understand is that hepatitis B impaired my liver and my liver is impaired because of the hormone treatment. Why I say because of the hormones, I am very health conscious. If I get a light cold, then I go to the doctor. Even though the doctor thinks I'm oversensitive. I have never experienced such things in my life, and what makes it sad for me, is that I feel if the doctor, I still go for treatment, because if I understand the doctor correctly, look I don't have a medical background, the medication that they give, is the same medication that people who are HIV positive gets. So I'm on ARVs now. Like someone with AIDS. And it's medication that I have to use for the rest of my life because of hepatitis B."

Harriet knew about side-effects that could occur from being on hormone replacement therapy, yet she never believed it would happen to her. She is also willing to take health risks to align her physical embodiment with her gender identity.

Harriet: "For myself I was prepared. I knew what the side-effects could be, I never ... maybe it's something negative from my side, but I never accepted that it could happen to me, because my information was good when I search for help."

Ester reported having suffered a stroke as a direct result of her treatment:

Ester: *"The Premarin gives you hot flushes. That tablet is actually a woman tablet for menopause, but they put you on that so that your breast can start developing and your insides can start changing. I was on it for many, many years until I developed the stroke. I developed blood pressure and a stroke."*

Douglas: *"Tell me about the stroke. When did you have that?"*

Ester: *"Eight years ago."*

Douglas: *"Was that from the medication?"*

Ester: *"Well, that is what the doctors told me and that was when they started the Provera."*

Douglas: *"Did you have high blood pressure before the stroke?"*

Ester: *"No, after the stroke, only after."*

Following her hormonal treatment, Glenda was diagnosed with cancer and subsequently had a gastrectomy. Previously working actively in the engineering field, Glenda is currently declared unfit to work:

Glenda: *"Doctor K said I was lucky that I didn't bleed to death because it was a main artery. It was the 24th of May when they did the operation. The whole stomach was removed and then they connected the oesophagus with the small intestines. From there on the diet problems started."*

Glenda is of the opinion that her cancer was caused by stress rather than as a side-effect of the hormones. Could she be in denial about the link between the use of feminising hormones and cancer, because she so desperately wants to have a female embodiment?

Douglas: *"Glenda, do you think the changes that you experience in your body, do you think there is a connection between the gallstones, the cancer and your hormone supplements?"*

Glenda: *"No, they waited, look the Androcur and Premarin that I drink, and I'm on a cholesterol tablet. I had cholesterol then. I was very overweight. I'm also on blood pressure medication. My heart rhythm is also out and I'm on medication for that too. My heart rhythm just ran away. At stage a it's 80 and then suddenly 140. So it went up and down. That's why I drink the Bilocort. During the operation and the medication they said all the medication must be stopped. I was on half a Disprin per day, so they thought it was the Disprin that caused the cancer. But it was that. They then came to the conclusion that the stress in my work and the stress of my transition had caused the cancer. They discriminated a lot against me at work. The loads of stress that had; that caused the cancer."*

As with all other major surgery, sexual realignment surgery also has risks of surgical complications. Ester experienced various complications from surgery:

Ester: *"The fistula. You get the anus and the vagina ... When I came home and I begin to poo in front out of the vagina, toe kan ek nie verstaan nie? Wat gaan aan. Die moet dan agter uitkom! [I could not understand why the poo was coming out in front.]*

"I phoned the hospital and they told me to come in immediately. I got a car and went through immediately. They examined me and said I have a fistula and we cut a piece of your anus by mistake. They have to rectify it. I had it done and I had a bag [colostomy] for 4 years which I had to take care of. The bag was on here [pointing to the scar of the stoma]."

Douglas: *"Colostomy?"*

Ester: *"Yes and it irritated me very much, but I pulled through with the grace of God. Everything that I do is by the grace of God.*

"When the other doctor, I had a problem when my vagina was made. It was just created and they left it and I took a very small mould in me, just to get the passage open so that they could make the vagina and after two years they made my vagina. All he has to do now is to take me to theatre and open it up that is all."

The experiences women have with side-effects leave various questions. It seems that Glenda is in denial about a possible connection between her cancer and the use of feminising hormones. Harriet seemed aware of possible complications, yet she took the risk of treatment and continued after suffering major side-effects, and Diane merely accepts sexual dysfunction as part of the process. This strong yearning to have their bodies realigned to their gender identities is so strong that transsexual women will ignore and endure negative effects to strive towards organic womanhood.

6.3.4 Mental wellness

While feminising hormones and surgical interventions contribute to the experience of physical side-effects, literature alludes to the fact that there could be a direct link between the use of feminising hormones for sexual realignment and depression. The bulk of participants in this study either have suffered or are currently suffering from depression.

Allison discussed her experience of suffering depression in detail. Suffering depression had a negative impact on her occupational and social functioning:

Allison: *"As in mood hmm levels was not always as it should be and sometimes I was very, let's say now teary at the beginning or I was just very ... almost like one who would like a women now will, let say, menstruate, then the mood would be a little off. It fluctuates in one day's time up and down in her life.*

"We're all human, so I went through a stage where I was very down down down and that was the time when I dropped out of my course. This is now very, very, very personal stuff that I haven't even discussed with my closest friends, so it was a time when everybody had a story about me, 1998, 1999. When I had to complete my course in my fourth year and I didn't finish, it's part of the stuff that was negative from a career perspective and the fact that I was now transsexual. So if you find me, you know how it was at Hospital D, everybody talks about everybody. Now they find you after work and you're dressed up, because I went out like that every day. Now they get me in the shopping mall and then it's a story tomorrow at work. So, I just felt enough is enough and this was plus minus six weeks before I had to write my finals. Now any clear-thinking person would think that she is mad to quit just before the finals of a four-year course and go off. So I just felt that I had enough, I'm packing my suitcases and I disappeared and went to Vredendal. And there I went to stay for two, three weeks on a farm with people. My mother and everybody were searching for me, but I just felt ... and the work was looking for me and I came back and wrote a letter of resignation. It was one of my lowest points in my life. Because you don't get that support as a transsexual health worker. It's very difficult. Extremely difficult, and I experience it still up to this hour.

"But then I felt so down and I need a push from someone that can say YOU CAN. You fell but you can go try again. And always I came back home and again just lay around the house, and then I went back to the Cape for the last time, I go again. Then I had a ten rand that day with me and I think Lord please help me that I can get to Athlone so that I can get to the agency Nursing Services."

The correlation between depression and the use of feminising hormones becomes more apparent in Caroline's case:

Caroline: *"That happened round about ... What I was told by friends that the depression story will only happen for the first three months. Which it didn't, mine started the 4th and 5th month and in the 6th month, and by the time it got me I was at an all-time low at that moment ... Ja, just happened at the wrong time."*

Depression does not only impact social and occupational functioning; various women who participated in this study attempted suicide at one point or another in their journey of becoming, as in the following cases:

Allison: *"So I drank a handful of pills and was admitted to Hospital D."*

Ester: *"Suicide, God, I wanted to throw myself out of the window at Hospital A, because I could not take the pain. The pain was too much to bear. I looked at*

my body. All the marks on my body the way they cut me, what they did to me. I can't talk about it. [Crying]"

Glenda: *"No, I had a double-barrelled shotgun. I had with the fighting and everything with the family. We fought a lot. I was emotional. Very, very emotional. I took out the shotgun and loaded the ammunition..."*

6.3.5 Surgery

Feminising hormones can assist with breast development and bring about subtle changes to the bodies of transsexual women. They would, however, need various surgical interventions to completely realign their bodies to their gender identity.

Transsexual women have a strong urge to become 'complete'. This is depicted in the discussion with Imelda who is on the brink of completing her studies and desperately wants to enter the professional world as a complete woman. She feels that her incongruent physical embodiment is placing her life on hold.

Imelda: *"I asked him that I need to finish this. I am going to start working soon. I want to go into the work environment as a complete female. I don't want people to look at me and then everyone is saying afterwards: 'She was a man!' I want to walk in there as a complete woman.*

"I did not get that from them. It's almost like they are making this process such a ... I heard from a friend that it is going to take ten years. For me to wait ten years ... My life is over. I need to start now, to be successful."

Being complete for Imelda consists of not only using feminising hormones, but having complete top and bottom surgery:

Imelda: *"The process is being dragged. Four days a year. Why is there no funding for us? Some people say it is unnecessary. It might be unnecessary for them, but it is not unnecessary for me. This is my life. I want to be the person that I always dreamt of being.*

"Obviously I am going to because in my family our breasts are very small, so I think this is it. It stopped now and I explained it to the plastic surgeon as well, my breasts have stopped growing. Obviously I am going to do the vagina as well. There is something that I wanted to say, but I forget ... It will get back to me."

This desperate need for surgery is depicted in her dreams of winning the lottery to have the surgery completed:

Imelda: *"I believe that everything is going to happen soon. Maybe I will win the Lotto. I was actually sitting and wondering, if I feel like this, how does the other girls feel? If I could win 20 million rand now, I will make some of the money available ... not all of it [laughter]. I will make some of the money*

available to help some of the girls. Because obviously they also feel like me. They are held back."

6.4 Subordinate theme 2: Facing the giant in order to become

This subordinate theme reveals the relationship which exists between transsexual women and the healthcare system. The following clusters built this theme:

- Practitioners
- Being kept in the dark
- Care
- Access denied.

6.4.1 Practitioners

Realigning the physical embodiment of transsexual women needs a functional multidisciplinary team in order to facilitate a smooth transition journey.

More than 40 years ago Janet underwent her surgical transition under the conservative apartheid government. Although unclear, it seems that the care which Janet received formed part of a research project and she was merely used as a subject. However, when Janet speaks of the care which she received during her transition journey, she labelled the doctor as a genius, she describes the nurses as being knowledgeable, skilful and friendly, and she describes a functional multidisciplinary team:

Janet: "That doctor was a genius. Pity he is no more. At that time it was perfect because at the gender conversion clinic it was perfect. You will never get that service again in this day and age. I mean the health care system that was run by the Afrikaner [government] was the best in the world.

"... the nurses were outstandingly caring. Wonderful. Nine o'clock in the morning after you have had your shower or bath, and your breakfast, and then the nurses will come, the doctors will come and they will examine you every day. Every morning they would examine you. The treatment was wonderful, wonderful, wonderful.

"A team, right, it was the clinical psychologist, the social worker and ... can I remember now. There was a team of about six doctors."

The care Janet received was holistic and she was supported throughout the process:

Janet: "You were taken in the week and then by the end of the week in the evening, the plastic surgeon will come and the surgeon himself to come and see if there are any complications with family. They interviewed the family as well. They looked for problems with family. Any objections from religious leaders like priests and that sort of thing."

Douglas: "By the time you left you were fully recovered?"

Janet: "Yes I was fully recovered and then I was given my medication to take and Eusol to bath in because you had to clean the wounds with Eusol and that was it. Until you could go back to work, and I was very fortunate in Johannesburg at that time."

That was the care which the multidisciplinary team offered in the 1970s for selected transsexual women. Today, however, the picture is completely different. Certain healthcare practitioners possess and exert power over transsexual women, the multidisciplinary team seems to be out of sync in relation to the care of these women, and their competence, ethos and professional practice are in question.

The plastic surgeon is perceived as the person who holds the power over when, where and how transsexual women will have their surgery. Harriet's initial surgery was cancelled under dubious circumstances which left her feeling powerless:

Harriet: "Ok, ja, hmmmmm, the reasons that were given to me. There were three reasons. I will start with the doctor's. Or let me begin with when I was still in hospital. I was on nil per mouth from the previous evening 10 o'clock and the next morning the doctor has to operate. The time went on until 3 o'clock and I became hungry and got up and asked the sister, but is the doctor still planning to do the operation? And she said as she understood it he is not going to do it, because hmmmm someone else who he had to do the previous day ate and he couldn't do her. She understood he decided to do her in my place. So I did, I wasn't happy about it and I couldn't confront the doctor immediately, because he was in the theatre busy with operations. But one of the other ladies who was admitted with me, who wasn't trans, that was admitted with me the previous day, then said when she was pushed out of the theatre after she awoke, because I was supposed to go in right after her, she said she hear that the doctor said or the porters asked whether they should bring me in and the doctor said no they shouldn't, they should bring in the other woman. This is the version of the nurse and one of the patients that was in the hospital.

"I laid and I waited for the doctor to come and explain if he is going to do me. Must I stay on in the hospital? Should I still not eat? All that the doctor came back to me was that he let the sister know that I can eat. He came back to me after the operation and then he told me but he had an emergency and he couldn't do me. That's all that he said, and he will phone or contact me with a new date. Up till today I am still waiting, and this was June 2013. It is already October, almost end of October, and I've heard nothing yet from that doctor. However, I went to see the endocrinologist in September, and he had to give me another letter, a reference letter to give to the surgeon, that I can have another appointment with them January 2014."

Ester feels that the plastic surgeon is playing God in deciding on the fate of transsexual women. She is in need of a procedure to open up her vagina that closed over the years. She

feels completely disempowered due to the fact that he treats her with disrespect and is dishonest with regard to her treatment plan:

Ester: *"I am very uncomfortable with him, but I am comfortable with the other doctors. I even told him he is not playing God, he is put there for a reason to ... He took that position to do that type of work so he must do that type of work. Don't turn people away, don't be nasty with us! He is very nasty. I told that to him in his face Tuesday. I was there ... Oh God help me. Fucket. Life is a terrible journey that nobody can explain.*

"Upset. Upset, very upsetting. He is not a very sympathetic doctor as I have told you. He will say that thing and it stays just like that. He won't listen to you and say sympathetic words. If he says no, it's no. Like he knows I need this operation badly before my vagina closes.

"... Like he knows I need this operation badly before my vagina closes. He knows it, so why doesn't he just do it and finish and klaar. I must go buy me a vibrator. I must go ...oh Jesus, God am I now a lesbian om als te doen [to do all those things], but I do it just to keep my vagina open. I need it opened and doesn't want to do it. I must go in five months' time, but I don't know for what. So I asked him why I must come back because he said no for three times. Why must I go back again. He couldn't give me an answer."

Doctors are found to be uncomfortable when they treat transsexual women, and they often seem to be more inquisitive than committed to providing a quality health service:

Caroline *"...And in many instances when I have spoken to a doctor out of the endocrine clinic and look at my folder and look at me, he looks confused. It would be uncomfortable. With most I have found that they were professional and with a few I think, it has happened with me once or twice, where they were direct and would ask if you are transsexual [softly]. One was so blunt to ask if you are actually a man."*

Brenda: *"Ja, it's this kind of, you can describe it as an awkward moment [laughter] when you are sort of with the doctor and he is kind of hesitant, especially with a male doctor that is examining you hmmm, he didn't check your folder.*

Harriet: *"... One doctor at Hospital A told me plainly: 'Why aren't you happy with your body? Why can't you be a man? The men in society are already so few, and then you still want to be a woman.' I referred the case to the transgender board and nothing happened about it."*

The manner which doctors display have made transsexual women lose hope, and made them feel that the doctors do not understand the struggles transsexual women face:

"... because I still believe the doctors do not understand what it is to be trans, because they've never been trans in their lives. They don't know what an embarrassment it is to be a woman every day, to live like a woman and then your body, your private parts are male. They don't know what it is for you ... I believe the Lord made us all to love and be loved. They don't know what an embarrassment to tell men every day that you're sorry you're not interested, and then you are actually interested, and to lose your chance on happiness and love in life. So I think they don't take it seriously."

The health system is not only run by doctors, but the treatment that nurses render remained fairly unremarked during most of the interviews. Brenda, however, experienced the care provided by nurses as friendly. This could also be viewed as the nurses providing superficial care, and missing opportunities to render care to transsexual women:

Brenda: *"Uhhh, well the nurses are quite friendly, like I said they are also very sensitive not to offend you. The conversations that they have are friendly you know. They stay away from anything that would seem discriminatory and uhhh and it is something that I appreciate. But coming to the endocrine clinic, you see the nurse for a short while. They take your folder and you get weighed and they take your bloods. So it is minimal contact with the nurses, but we do have these friendly conversations."*

When the other women commented on the care which they received from nurses, the experiences were generally less positive. The conduct of nurses seems unprofessional and they find transsexual women as some form of entertainment, as reported by Caroline:

Caroline: *"So they call you into a room and tell you this and that. But it is like they see a trans person for the first time, every single month when you Come here. It's like Guy Fawkes [laughter]."*

"... And they will come in and then they pick up the folder and then they will look at you and call their colleagues and it is now a big joke."

"And I was rushed to B, day hospital ... Went in there, and then ... one of the sisters came over, and hmm, took blood and all that crap. Told me to, uhh, take my clothes off. I took my clothes off and she came in there and just said Ohhhhhh, and just went out again. She came in with two more sisters. And I was like, ok, it was now ok for you to be alone here to do whatever you needed to do, so what is this now. And I knew it was for the fact that they could see breasts ... and the bottom part was not what is was supposed to be in their eyes. And I felt embarrassed."

Douglas: *"HMM."*

Caroline: *"And, ok, I sat there. I was heavily depressed, and the stuff I took was an indication that my depression was at an all-time low. And for her to be"*

so stupid to still do that shit? Hmm, actually made me wish that ... I actually died that moment when I took the tablets. And that was that. [Silence]"

[Caroline breaks down and cries]

This unprofessional conduct is substantiated by Francis, when she reports on her admission at a district hospital:

Francis: *"I couldn't really hear, but there were people who came to ask about what is going on here now. What are you? I explained. Yes, it isn't..."*

Douglas: *"How does it make you feel?"*

Francis: *"It made me feel very uncomfortable, but I got over it and yes, it was just an experience that I don't want again."*

Janet is of the opinion that current healthcare staff are unprofessional, nurses lack dedication, and the caring aspect of nursing has completely disappeared:

Janet: *"I am going to say something now, but I don't know if I can. I was lying on the trolley there and I told them I am not feeling well and asked for a pillow. The sister said I should not ask because the Kaffers [derogatory word for a black person] stole it all."*

"I mean how can you say something like that. You don't use the K word!!

"I think that the nursing schools should be more strict with everything they do. They should be very disciplined and more dedicated in what they are doing. Otherwise they should not be doing that kind of work. It seems like it's just a job where they get a salary and not a career, and yet it is about caring. They should be more dedicated. They just thinking of the salary and the pension thereafter. There is no care, and that is what nursing is all about. It is about caring and providing care. The love of it and the love of people. How to speak to people, not by answering people rudely. That is a No-no."

The manner in which transsexual woman are treated by healthcare providers has made them question their competence:

Who?: *"... when you do it through the state you have to go back two or three times, and I think it's very traumatic for your body and you don't want that, because you want to be done with that. That's just my opinion."*

Francis: *"... My experience is what I heard from other transgendered women that if you go through the State it's not always a success. This is what I'm actually worried about, because you as a woman want to be perfect. You don't want a mistake because you're already a mistake."*

Brenda: *"Generally ... No, I don't think so. I think there is still a lot of work that needs to be done with training to make sure that they are experienced especially to work with trans women."*

***Ester:** "... He is just a doctor, I was under professors. When the other doctor, I had a problem when my vagina was made. It was just created and they left it and I took a very small mould in me, just to get the passage open so that they could make the vagina and after two years they made my vagina. All he has to do know is to take me to theatre and open it up, that is all. If he is qualified to do it. That is what I even told him on Tuesday. If you are qualified to do it then you will do it. But I don't think he has the qualification."*

6.4.2 Being kept in the dark

Transsexual women need to be prepared and empowered throughout their journey with adequate health education. Being armed with the correct health education will not only assist women to promptly identify problems with their health, it will also strengthen their power as autonomous beings.

Before the commencement of hormone treatment, women felt that health practitioners did not prepare them adequately on what to expect on their journey:

***Harriett:** "Yes, I did, let me put it like this Douglas, I feel I prepared myself good enough. I don't think the people that put me on the treatment prepare me well enough for this. The reason why I say so, is that it's a fight every time I go to Hospital A to see endocrinologist. We fight every time and then I come back and don't feel happy and I fight with them over e-mails, because I feel they don't open up to me. What happens at Hospital A is usually the main doctor won't see you. There are other doctors under him that see you. It's understandable and I told them the first few months of my treatment, I know what the medications does to you, but I know what my body needs and I asked them but why don't they prescribe blockers for me, and all these types of questions. I never got a real answer from the doctor. Every time when I get to the doctor, and this is my honest feel, they made me sick. I shouldn't feel like that but I know it's probably not the truth, but I feel they made my liver sick. They kept me on treatment but they never told me that they can't prescribe blockers to me. Until I put my foot down and told them I will not go before I get my blockers."*

"They got the main endocrinologist, Doctor Y. Doctor Y came to see me when I was on the treatment for a year already. He sat me down and really explained what is wrong with my liver, why they can't prescribe blockers for me, and then explained that the tablets or the Premarin that they prescribe affected my liver and they can't give me another pill that could also affect my liver. So I feel I was prepared for that, but I didn't know there was something wrong with my body, and they as medical staff really didn't prepare me. For myself I was prepared. I knew what the side-effects could be, I never... maybe it's something negative from my side, but I never accepted that it could happen to me because my information was good when I search for help. But they were never truthful with me until it happened that my liver was affected, so that now I possibly don't even know what they're going to do about my liver, because I'm already

at Hospital C for liver treatment, and if it does not improve they will send me to Hospital D."

Caroline: *"I think they didn't, they don't prepare you fully. I think they just ... tell you the basics that they think you need to know."*

Health education is experienced as being superficial and is frustrating:

Imelda: *"...But for me to sit and wait for my file and then to sit and wait for him. For me to be asked all the time if I am still smoking? Why am I going to the hospital? I could give them the information on an email. They only show me now in order for my vagina to work; I need to stretch the skin of the penis. They are only telling me that now. It is the third time that I am seeing them. That also tells me that they are dragging the process. You understand?"*

"...Yes, Yes, I want to start my life. At the moment I did not start my life yet. I am sitting in my room and watch TV. I am waiting for someone to give me a go to start my life, and I can't start it without the changes."

In some cases there is a complete absence of health education:

Douglas: *"Tell me, Diane, do you smoke?"*

Diane: *"Yes."*

Douglas: *"Ok, and nobody spoke to you that smoking and the pills can be dangerous together?"*

Diane: *"No, nobody did. So is it dangerous?"*

Keeping transsexual women in the dark not only disempowers them, it also strengthens the assumption that health practitioners hold the power over transsexual women. In Harriet's case, she is even blaming the doctor for her current ill state of health:

Harriet: *"...I don't think there are other things that I've picked up on. This is what I experienced. The hepatitis B and it is very serious, I don't accept the doctor's explanations about why I have hepatitis B. They say it has to do with my growing up years, and my liver just waited for something to let it come out. It could've been water, it could have been where I played, but I'm not satisfied with their explanations. They don't open up to me!*

"I never got a real answer from the doctor. Every time when I get to the doctor, and this is my honest feel, they made me sick. I shouldn't feel like that but I know it's probably not the truth, but I feel they made my liver sick."

Even though the provision of health education forms the basis of preventative health care, healthcare providers are not equipping transsexual women with adequate health information. This leaves them to find information from other

transsexual friends, and they are not sure if the information which is circulating in the transsexual community is accurate:

Caroline: *"No, I clearly don't. Like, just for the fact that last night I slept by my friend who is actually here today. And she is now almost three months on treatment. And most of her information she got from me. And whereas I got it from somebody else. But it didn't come from the professionals ... and I don't know if it is the right information."*

6.4.3 Care

Providing sensitive care to all people is the basic function of healthcare professionals. The care which transsexual women experience is of an inferior quality. The ill-treatment which they have to endure each time they visit a healthcare facility leaves them feeling that they are second-class citizens.

Harriet expresses fear of transphobic attacks should she visit a government healthcare facility:

Harriet: *"...Yes, I will really borrow money to go to a private doctor because I am scared of transphobic attacks at the clinic. I am really scared for that, and the reason why I'm afraid is because I'm afraid I can be locked up for it. I'm not one to let my human rights be taken or trampled on."*

This fear is not unwarranted. Francis was ignored in a district hospital post-surgery when healthcare practitioners 'discovered' she is transsexual, while Caroline was refused a bed in a tertiary hospital as there are no beds available for transsexual women:

Francis: *"The day I went into the theatre, they booked me into the female ward. The next day when I went in for my operation, it wasn't even half an hour thereafter, then they moved me out to another ward. So I wondered why. Then I heard that they can't put me in a female ward because I'm not a woman. They put me in a small ward privately and left me there. It's like someone who has leprosy. The doctor never came to see me; I had very, very little contact with anyone there. I was disappointed, really I was."*

Caroline: *"... And they left me at reception until a doctor could come there and he took me to a room where we could be alone, and did what he had to do, and then from there I had to go back to the waiting room and sit there until I could see a psychiatrist, because there is no wards for trans women."*

A general theme of ignoring transsexual women surfaced, when they are in need of care beyond care for their physical transition. Ester highlighted the absence of care she received in a rural area after her stroke:

Ester: *It was very very bad. They just give you your tablets and finish and klaar. I took myself to physiotherapy. I took myself to the gym to get my arm right and my leg right. I did my own speech therapy. Everything on my own.*

Which is not nice. There is no help for you because you are that type of person, you know? It is not nice."

Being constantly ill-treated at healthcare facilities, transsexual women strongly felt that they are not seen as a priority in the healthcare system:

Imelda: *"They don't say it, but their attitude of 'They can wait'. I mean I told them a month ago I need hormones. It's not that I didn't inform them and I just came there to pick up hormones."*

Caroline: *"I'm actually angry! I feel that somehow, I am getting the short end of the stick just because I am trans. Or just because I am not so-called normal to what people think normal should be. Because I mean honestly when did you decide what should be normal and what's not normal? I mean if I had a choice, this is most definitely not a road that I would have picked for myself."*

"... it makes me feel like it's senseless to go ahead, that I can't explain, but it makes me feel you are not important in the eyes of the world, or that people that can help you or have the necessary knowledge, have the necessary facilities to help you, they don't see you as important. They don't see your body as important, and they don't see your emotions as important, so it feels to me I'm just on a list, but I'm just there. So, I'm just a number. It's nothing else but a number. I don't want to feel like a number, because I believe numbers belong on telephones and I feel I am a human being and much more important than a number. And yes, I... SIGH, SIGH, SIGH, TEARS."

Juxtaposed to the current state in which care rendered to transsexual women finds itself, is the functional care which Janet received in the 1970s. She described the health service of the time as world class:

Janet: *"That doctor was a genius. Pity he is no more. At that time it was perfect because at the gender conversion clinic it was perfect. You will never get that service again in this day and age. I mean the healthcare system that was run by the Afrikaner was the best in the world."*

Could this level of care which she received have contributed to the fact that she never experienced any side-effects during her 40-plus years of her transition journey?

6.4.4 Access denied

In order for transsexual women to strive towards organic womanhood, they would have to access the healthcare system for their transition-related care. It could be said that the system and the practitioners in the system hold power over transsexual women, by either allowing or denying them access. Money is also a barrier to care for transsexual women, and this barrier is present in the private healthcare system as well as the government-funded healthcare system.

The power of the practitioner is so strong in some cases that access could be denied outright. This is evident in the case of Francis, who tried to access care to assist her transition more than 20 years ago:

Francis: *"... They put me under hypnosis and asked me all the questions. He recorded everything on tape.*

"... When I was out of the whole thing, then I had to write down everything that came into my thoughts, but according to him the tape-recorder didn't work. He was supposed to play it back for me. According to him the tape- recorder didn't work. Then he came back after a week and said he was sorry, but it can't happen, because according to him I am, I go into a state where I'm basically gay. He can't let me go for surgery, or for further examinations."

Access is not always denied outright to transsexual women, yet there are a strong feeling that delay tactics are used in order to prevent progression of their journey of transition:

Allison: *"The reason, let us say it's like this, you aren't helped thoroughly on the government side. Now I must get a date for a specific person at out-patient. The psychiatrist or one of the doctors that is part of the group that works with the reassignment patients, then it is always vague or the dates are rarely on time. And hmm if you come there then they say there were overbookings, and you must postpone and the dates are far away, because it's such long list, the dates are apart from each other. Three months apart, so it really put me off at Hospital A, that it's always so vague and scanty."*

Imelda: *'My hormones were always late. I know if I don't take it ... I stopped my hormones for two months and I could see my body changed. Hair came and I could feel something is different and obviously the hormones were leaving my body. They did that, it's almost like they, you know what they say, they can wait!"*

These delaying tactics which are present could be practitioner-dependent. However, the question arises as to whether there is the political will in the healthcare system to grant access to trans services. Without the necessary political will, practitioners themselves would be prevented from granting access:

Imelda: *"The plastic surgeon, his personality when you go in there, his personality is stunning, but I can also see that maybe there is another party that is maybe dragging the process ... you understand? I can see that he tries to answer my questions, but he can't actually answer it, and he will stick to the answer that he only has 4 days and there is not enough funding. He told me Gender Dynamix is raising funding for some girls to do some surgeries. I asked him what I can do to get more days in theatre, and he told me I can write a letter to provincial government and maybe I will get a response."*

There is no other manner to articulate the need transsexual women have to access trans services than as sheer desperation. It is this desperation which leaves them vulnerable in the hands of the health system and healthcare practitioners. Women will do anything to get care. Janet was part of a research project and sworn to secrecy in order to get treatment. She also had to fit a certain mould in order to have the 'privilege' of transsexual healthcare services:

Janet: "Yes, you had to be a voortrekker vrou, an Afrikaner tannie [aunt]. I mean really."

Douglas: "No high heels?"

Janet: "It had to be a sensible court shoe. En moenie met n mini kom nie [don't arrive wearing a mini]. The dress had to be over the knee. A camisole and a decent jacket. Not a lot of make-up, understand. Just minimal. Everything had to be soft.

"There is too much that I can do. You know when you went to the gender conversion clinic all those years ago, you know, those years, everything was extremely conservative and being in an Afrikaans environment. I mean die NG Kerk. If you came in dressed inappropriately, you were frowned upon. You could not come with things down here and open stomachs and things. You couldn't. You had to wear sensible shoes. It was like it was run by the church. The church was the head of everything you know, and all those Afrikaner people would look at you if you came in otherwise. And I still prefer to live like that."

Money is seen as a barrier to accessing care for all the transsexual women who participated in this study. Having a middle-class income and health insurance does not exempt women from struggling to access services. Health insurance companies see transsexual healthcare as cosmetic, and does not cover medication and surgery. When challenged, they are willing to discuss a 50% co-payment for surgical procedures:

Allison: "Hmm, I go to my doctor for the prescription and then I pay for it myself at the pharmacy. The medical does not pay for it.

"As I said, doctor has told me, I have to write a letter to the medical aid from myself first, which I did. Then they told me that the doctor who saw me and who referred me to the psychiatrist, that psychiatrist must write a motivational letter to say, hmm, state of mind is of such a nature that my whole thinking and everything asks that I do get the operation."

Douglas: "Ok."

Allison: "So then they can consider it and put it on the table that there is a chance that 50/50 is that the medical aid pay and I the other half. Say the operation is 30 000 and then I'll pay 15 000."

Referring back to political will in the government healthcare system, it is noted that the same practitioner who could not offer trans surgery to transsexual women is willing to assist them

in the private healthcare system at premium rates. However, this option is unaffordable for most transsexual women:

Francis: “...Doctor X will charge me R45 000 private if he will do it, but a week in the hospital is R120 000. So what is the use you pay almost R150–160 000, and then you must go back again because Doctor X does not do everything at once. It’s again a time when you must go to hospital and all those things. In my opinion it is not worth the effort to have it done here. If I had the money I will be in Thailand tomorrow.”

Caroline: “... I asked them how much it will cost and he said that private it will cost R30 000 for the breasts and R100 000 for the vagina. Do you want to wait ten years or are you going to pay that R130 000 rand, and obviously there is more money afterwards that I will have to pay. You know, paying for the cotton wool and all.”

Receiving subsidised care from the government healthcare system is not free. There are hidden costs to treatment which women face. This barrier to access becomes even more apparent the further the woman finds herself away from the city:

Imelda: “... If they tell me they are doing the surgery, they must give the full package. I have to go to Cape Town every second month for laser treatment. It costs a lot, but I am doing the face part and then I have to do down here because they want me to do down here. At the end of the day it is going to cost me such a lot of money, where Brent said that there is a machine available at Hospital A, but no one is talking about the machine! If I should tell you how much money I gave out already for this, you are going to wonder if it is worth it. You are going to think why I didn’t just go to Bangkok where they do everything at once, save your money and go to Bangkok.”

Women have become extremely frustrated with the South African healthcare system and the only way out to them would be to go to Thailand to have their surgery. This option is available, but it also comes with a price tag:

Francis: “It’s my biggest aim. My plan was to go to Thailand this year to have my operation, but unfortunately with financial circumstances we could not do it. To go through the State, that’s just impossible. The waiting list for people to go is just so long. By the time I have to go, I’ll probably be 80.

“I already got the costs from the doctor. It would’ve cost me this year R85 000, and then that’s my plane ticket, accommodation and with everything, so plus minus R120–130 000 all included. Doctor X will charge me R45 000 private if he will do it, but a week in the hospital is R120 000”

6.5 Conclusion

Through in-depth description of the voices of the transsexual women who participated in this study, I presented the data in this chapter in an organised fashion using the clusters and themes which developed during the process of data analysis. The reader could make sense of the master theme graphic (Figure 6.1) which emerged from the data, and could evaluate the accuracy of the theme graphic by becoming immersed in the voices of the participants which followed.

In the following chapter the findings of this research will be discussed and supported with reference to the current available literature. The findings of this research will also be operationalised, and appropriate recommendations will be made.

7.1 Introduction

Within this chapter I have utilised the analysed data of this study and available scientific literature to discuss how the objectives of this study as listed in chapter 1 were satisfied. In this discussion the assumptions which I held at the outset of this study are clarified with the aid of the data which were analysed and presented as a master theme graphic in the previous chapter (Figure 6.1), and relevant scientific literature.

7.2 Transsexual identity

Before I can discuss the relationship which exists between transsexual women and the healthcare system, it is important to discuss how transsexual women identify, as the manner in which people self-identify is at the core of their being. I will dismantle the identity of transsexual women by separating gender identity, sexual orientation and sexual practice, in order to present the multi-layered identity of these women.

Society finds comfort in categorising people into specific groupings. For some reason it creates a sense of order and safety. This is evident in the gender binary which is automatically used, in which people are assumed to be either male or female with no space for genders identifying beyond or in-between this binary (Budgeon, 2014). Society has also grouped people with a different sexuality than heterosexuality under the umbrella term LGBTI, and it is assumed that they share commonalities and are a homogenous grouping. Even in healthcare there is a practice of grouping people and illness conditions in a manner which will result in a 'one size fits all' treatment. This practice is so completely ingrained in the minds and practice of society that it is rarely questioned.

7.2.1 Gender identity

Transsexual women are women. Their thinking resembles that of women and they identify strongly with other women. This was true of the participants in this study, who always referred to themselves as women or transsexual women. It is significant to note that the women in this study who are in the process of sexual realignment would refer to themselves as transsexual women, whereas the participant who had her realignment surgery completed in the 1970s never once used the term transsexual or transgender, but merely referred to herself as a woman. In this particular case I observed a feeling of being content with her identity; this was juxtaposed against the sense of urgency of other participants, who desperately wanted to jump the gender binary hoop in order to find inner peace. This was highlighted by one participant, who felt that her life is currently on hold and without surgery she will not be able to live her life. It was noted that not once in my encounters with participants did they ever refer to themselves in the masculine.

Current quantitative research conducted in the USA demonstrated that a statistically significant amount of MTF transsexual women will strongly identify as women. They have

also found that the transsexual women who do not have this strong female identity would identify strongly as transsexual (Dargie et al., 2014). In another USA-based study it was found that at least 73% of the MTF transsexual participants in the study self-identified in the feminine, and another 9.8% identified as transgender (Witten, 2015). This research confirms that the identity of transsexual women leans strongly towards the feminine if measured against the traditional gender binary standard of male and female.

Having access to feminising hormones could be described as a blessing and a curse for the identity of transsexual women. As soon as these women start with the treatment of feminising hormones, they start to feel a harmony between their physical embodiment and their female gender identity. Some participants mentioned that they started to feel less stressed, could concentrate more and started to have better control over their emotions. All of this could be seen as positive moves towards the status of women. However, without adequate access to surgical sexual realignment, these women are essentially moved to an in-between embodiment state. This could cause further distress as they will be able to pass as a woman within society, yet they have a body which can limit them in expressing their femininity at all levels without being questioned.

It has been found that the initiation of feminising hormones for transsexual women will positively affect their mood and self-esteem (Gorin-Lazard et al., 2013). Besides these improvements, it has also been found that transsexual women will have lower levels of anxiety and distress than their counterparts who are not utilising feminising hormones. These positive maintaining factors to the mental health of transsexual women are deemed to be present at the same level for both pre- and post-operative transsexual women (Gómez-Gil et al., 2012). However, the results of this study have shown that feminising hormones might contribute to the general mental well-being of transsexual women, but they remain limited as women while they remain in the pre-operative state. Therefore advocacy for the swift physical transition of transsexual women is imperative to maintain their mental well-being.

7.2.2 Sexual orientation

Sexual orientation is the inner attraction which you have towards another person. Sexual orientation could be defined as homosexual where you are attracted to a person of the same gender; heterosexual where the attraction is towards the opposite gender; or pansexual where you could be attracted to a person of any gender (Galupo et al., 2014). The sexual orientation forms some part of a person's identity.

In this study all the women who participated identified as being heterosexual women. The participants who are not in long-term relationships all had a yearning to be in a relationship with a heterosexual man as their intimate partner. From the findings of this study, transsexual women reported it to be challenging to negotiate intimate relationships with heterosexual male partners, as most of them were still in the process of gender realignment. They have a fear of not being accepted by men who are interested in them should they find out that they are not 'women' in the general sense accepted by society, or they would be classified as a freak. Being physically in-between genders also carries the risk of becoming a

victim of violence and hate crime, should a man find out that they are not a 'normal' woman. One participant eloquently described this as "discovery murders", that is when a man finds out that you are not the woman that he thought you were, he will kill you. This fear of being ostracised, judged and even killed leaves these women lonely and prevents them from fulfilling the basic need of belonging.

This type of violence directed towards transsexual women can be described as transphobic violence or hate crimes. The experience of the prevalence of transphobic violence has been documented to be as high as 57.4% among transsexual women (Hwahng & Nuttbrock, 2014). However, it remains a challenge to quantify the occurrence of transphobic violence directed towards transsexual women because often crimes are not noted as being of a transphobic nature, or this phenomenon is reported in the collective with all other violent crimes committed against LGBTI people (White & Goldberg, 2006).

The findings revealed challenges of sexual orientation and sexual identity among some of the transsexual women. For instance, one participant had been married to a woman for over 20 years and now finds herself in a same-gendered lesbian relationship. One of the other participants finds herself in a heterosexual relationship with a homosexual man after they had been in a homosexual relationship for over two decades.

Both these women have a current struggle with their new identity. The first mentioned is now practically in a same-gendered lesbian marriage with a heterosexual woman as a partner, while the other participant is in a heterosexual long-term relationship with a homosexual man. The literature would describe this sexuality as pansexuality (Hale Gonel, 2013). These women find it challenging to express their sexuality in their relationships as the sexual attraction towards their life partners has waned during the transition journey, yet they remain in the relationship because of the love they have for their respective partners.

These findings confirm the fluidity with regard to transsexual sexual orientation as described in the literature. It has been found that transsexual women might report a change in their attraction to other people. This could be ascribed to changes which they experience with the use of feminising hormones, the external influences of society on what would be deemed as acceptable, and the current context in which they find themselves (Auer et al., 2014; Dargie et al., 2014).

7.2.3 Sexual practice

It would be incomplete to discuss the identity of transsexual women and to include their sexual orientation but omitting the topic of sexual practice. Even though sexual practice has a great influence on the health and well-being of people, healthcare practitioners often steer well away from the topic. Sexual practice can be defined as the sexual acts in which people engage, either with themselves or with another person.

Pre-operative transsexual women will usually suffer some form of sexual dysfunction, which is related to the use of feminising hormones (Bischof et al., 2011). The findings revealed diminished libido among some transsexual women. For instance, one of the participants

mentioned that she is never in the mood to have sex, yet she will engage in sexual activity with her partner just to satisfy him and to save their relationship. Having such feelings often has a negative impact on transsexual women, as they might feel that they cannot fully express themselves as women. The literature further suggests that the significant loss of libido in transsexual women might lead them to practice celibacy either post-initiation of feminising hormones or gender reassignment surgery (Auer et al., 2014).

Being a pre-operative heterosexual transsexual woman can also cause further difficulty and distress for them, as they are not equipped with the sexual organs of a woman yet have the need to express themselves sexually as a woman. In the absence of a vagina, transsexual women have to engage in anal sex, which is not fulfilling to them as anal sex is seen to be a practice of homosexual men and not that of heterosexual women. For instance, several of the participants who were not in long-term relationships prior to their transition struggled to negotiate intimate heterosexual relations because of the fear that prospective partners would not understand the fact they as women do not have a vagina.

The findings of this study revealed that transsexual women have a constant gender identity which is in opposition to their physical embodiment and would cause them to seek help to create a synergy between their gender identity and their bodies. Even though all participants in this study identified as being heterosexual, adaptations with regard to their sexuality occur due to their context. Finally, sexual practices might change as their bodies change with the help of feminising hormones and surgical sexual realignment surgery. It is therefore imperative that these three concepts should be separated and should never be taken for granted, as they might be different for each transsexual woman.

7.3 Mapping the health-related problems of transsexual women

I asked the women who participated in this study to explain to me how their health changed since they started the realignment journey. The findings revealed various conditions on the physical and psychological level in relation to health-related problems. The physical health problems can be classified into two categories: conditions which arose after the commencement of feminising hormones, and post-surgery complications.

7.3.1 Physical health-related problems of transsexual women

Hot flushes, skin rashes, general malaise and sexual dysfunction as minor side-effects of treatment were revealed as physical health-related problems for transsexual women in the study. Of the more serious complications which they experienced were hypertension, stroke, liver disease and cancer. One of the two post-surgery women who participated in the study suffered recto-vaginal fistula.

These complications related to the physical transition journey of transsexual women are well documented in the literature and confirm the health-related problems as reported by the participants of this study (Wierckx et al., 2013; Selvaggi & Bellringer, 2011; Tangpricha, Afdhal & Chipkin, 2001). However, almost all of the participants reported having a negative change in their physical health after the initiation of feminising hormones, and this

occurrence of negative effects on the health of transsexual women contradicts lower incidences described in the literature. I am thus of the opinion that transsexual women will underreport the negative changes in their health after the initiation of feminising hormones.

The side-effects transsexual women may suffer due to the use of feminising hormones are well documented in the literature (Wierckx et al., 2013; Wassersug & Gray, 2011; Wassersug et al., 2007; Elbers et al., 2003; Tangpricha, Afdhal & Chipkin, 2001; Reutrakul et al., 1998). However, there might be an issue of underreporting of side-effects which transsexual women endure. For instance, a participant in this study who suffered from skin conditions had never reported these to her care provider who manages her transition. She merely got a steroidal cream from the pharmacy and treats her ongoing skin conditions herself. Another participant, who suffers general malaise to the extent that it has an influence on her occupational and social functioning, has also never reported the change and merely started to make changes in her daily life to cope with the malaise. Even the participant who suffers from sexual dysfunction accepted this dysfunction and mentioned that she just thinks it's a normal part of the process. Such underreporting of symptoms might lead to ill-health in transsexual women, and might have a greater influence on other transsexual women because the causes of these side-effects are not investigated.

Questions relating to the transsexual women's reluctance to report side-effects or linking them to the use of feminising hormones are many. Data in this study revealed the following possible reasons for the underreporting of side-effects:

- Lack of information with regard to the effects which feminising hormones might have on a biologically male body;
- Possible denial that feminising hormones could lead to the development of side-effects; and
- A feeling of desperation to transition, with the result that they would hide side-effects from practitioners for fear of discontinuation of the process.

The possibility exists that transsexual women are not well informed enough with regard to the occurrence of side-effects while they are on treatment, to take the necessary action should these occur. When transsexual women decide to take hormones off-code, the hormones most definitely do not come with health education. This is evident in the case of the participant who gets her hormones from a friend who works at the local clinic. The other women who participated in the study said that the health education which they receive is both scanty and insufficient, or there is a complete absence of health education given by the practitioners.

Transsexual women will rely on each other for information. Taking into account that the population of transsexual women is small and that most of them will have access to the same medical practitioners, the information which they share could be unreliable in itself. It could thus well be that transsexual women think that these side-effects are not important and then choose not to report them and treat them without advice from a healthcare provider.

One of the participants was diagnosed with hypertension and other cardiac conditions after the initiation of feminising hormones. She was also diagnosed with gastric cancer and had a subsequent gastrectomy. She is of the firm belief that her current state of health is not related to the use of feminising hormones, but it is merely stress-related. The literature is clear with regard to a higher incidence of cardiovascular conditions related to the use of feminising hormones, but evidence is still unclear on a higher incidence of cancer related to feminising hormones (Wierckx et al., 2013). What is important to note is the fact that denial exists about the impact that feminising hormones could have on the health of transsexual women.

The other possibility might be that transsexual women are so desperate to have their bodies realigned that they will not report or choose to ignore side-effects, because they have a fear that their treatment will have to stop. It was observed that participants would first comment on the positive changes which they experiencing with regard to the feminisation of their bodies rather than the side-effects they experience, when they were asked how their health changed after the commencement of feminising hormones.

One participant described herself as an “addict”. She is so excited to be a woman that she will grab every opportunity to do things that a woman would do. In fact she regrets that she started using feminising hormones so late in her life. Such statements lead me to believe that a transsexual woman might endure side-effects because she sees the bigger picture of becoming a perfect woman.

7.3.2 Psychological health-related problems

Apart from the general physical health of transsexual women in transition, findings also revealed mental health-related problems, including depression and suicide, which occurred after the commencement of feminising hormones.

Findings revealed that related to depression experienced, three of the participants had made at least one suicide attempt. It was noted that the depression started to occur about three to six months after the commencement of treatment. All of the participants made a direct correlation between the depression they were experiencing and the use of feminising hormones.

Quantitative investigations have pegged the incidence of depression in transsexual women as high as 62% during their lifetime, which validates the occurrence of depression among participants in this study (Rotondi et al., 2011). The use of feminising hormones can also be a trigger to depression in transsexual women, and the occurrence of hormone-related depression is usually within three to six months after the initiation of feminising hormones (Rotondi, 2012; Wassersug et al., 2007). The link between feminising hormones and depression cannot be ignored, as health practitioners can anticipate the depression and ensure suitable support and management for their transsexual clients.

Literature suggests that depression among transsexual women cannot be viewed as a one-dimensional issue. There are various factors contributing to, maintaining and perpetuating the occurrence of depression in transsexual women. Factors such as violence, stigma, social

circumstances, chronic illness, substance abuse and being marginalised all are key factors which may cause depression (Hoffman, 2014; Rotondi, 2012). Similar findings were identified in this study. For instance, one participant reported stigma she experienced in the workplace, while another reported the pressure she experienced from her family who deny her existence as a woman.

Studies have also shown a higher incidence of suicide and suicide attempts in transsexual women both prior to and post-surgery (Matarazzo et al., 2014; Dhejne et al., 2011). Depression and suicide have direct links. It is thus advised that healthcare providers should establish if transsexual clients suffer depression at each visit, and do a suicide risk assessment in order to ascertain whether more support and possible treatment are needed.

Transsexual women do experience negative effects of treatment which manifest both in their physical and mental health. It also seems that there is an underreporting of these effects, either due to ignorance or a fear of halting their transition journey. There is also a risk of mental illness and suicide among transsexual women.

The responsibility for the management of these risk factors cannot rest solely with the healthcare practitioner, because there are multiple variables which impact on these health conditions of the women. Transsexual women also have the responsibility to manage their own health and should be able to identify ill-health and seek appropriate treatment. However, health practitioners are able to put strategies in place in order to minimise the risks of the negative effects which transsexual women may experience.

Transsexual women should be monitored by a competent healthcare practitioner on at least a monthly basis in the early stages of her transition journey when she is initiated on feminising hormones. Health education sessions should be thorough and continuous and should include all possible side-effects of treatment which they could expect. I would suggest that each transsexual client is equipped with a health education booklet which includes all the information about feminising hormones, and their actions and side-effects. Equipping the transsexual client with accurate health information will lead her to be more autonomous with regard to her health, and she will possibly seek care timeously should a health problem arise.

The mental health of the transsexual client should also be included in the general healthcare which she receives during her transition. Performing risk screening at each visit could identify clients who may suffer mental distress as early as possible, and could ease the management thereof.

7.4 Politics and trans-health

In order to fully understand the behaviours and experiences of transsexual women in the South African healthcare system of the day, the political influences of the past have to be mapped and described in context. Before 1994 South Africa was administered by an extremely conservative government which promulgated several laws to oppress and

marginalise the majority of its people under the banner of apartheid or separate development, while the white minority of the population remained serviced with benefits.

Under the apartheid government, sodomy was deemed a common law crime, and together with the Immorality Act of 1957, expressing yourself sexually as a pre-operative transsexual woman would have been a punishable offence (Sexual Offences Act [No. 23 of 1957], 1957). These pieces of legislation would also prevent transsexual women from obtaining care from healthcare professionals, as these professionals would have been employed by exactly the same government that would punish them for being immoral. The healthcare system of the day would also not prioritise healthcare for transsexual women. However, as early as the 1960s gender reassignment surgeries were performed in the South African healthcare system. This political climate contradicted the services which were available to some women during this era of the country.

The findings revealed that the participant who completed her transition in the 1970s described the care which she received as “*world class*”. She received holistic care from a functional multidisciplinary team, and from her described experience it seemed that she received extra-special care. This was also similar for the participant who had her surgery in the early 1990s. These two cases stand in opposition to the other participants who started their transition journey after the country’s liberation in 1994.

From the findings it is clear that transsexual women were treated separately from the general population. It was also noted that the women in this study who received treatment for their sexual realignment prior to 1994 are black women who were treated in a hospital designated only for white people. They were at the mercy of the healthcare team, who could decide who could and who could not have access to such treatment. They were also forced to sign a document which bound them to secrecy about the process, and exempting the healthcare team from accountability should anything go wrong with the reassignment process. This is in line with the fact that transsexual women remain vulnerable and even desperate for treatment, and that they would go to any length and take risks in order to receive gender reassignment treatment.

The question why the oppressive South African apartheid government seemed to be a forerunner on the gender reassignment front is also asked by other South African trans activists and researchers. At an international meeting Theron (2008) stated that South Africa was seen as the destination for gender reassignment surgery under the apartheid government, and that trans women would come to South Africa from other developed countries to have their gender reassignment surgery performed in this country. Furthermore, she also grapples with the question as to why a conservative country would seem so liberal. She confirms my assumption that the care provided in this era did not have the objective of assisting and empowering transsexual women, but that they were rather seen as a problem which had to be sorted out and then they needed to disappear: “In those years a person embarking on transitioning was also advised by the psychiatrist to rather disappear after surgery. Actually cut ties with everyone they knew and relocate, preferably emigrate”

(Theron, 2008). Such an approach could be viewed as being oppressive, as it would sever the family unit without any concern for the emotional, psychological and spiritual health of the individual and the family. Such an approach does not promote mental health and well-being.

Reviewing the literature of the apartheid era yielded very little information to confirm the speculations of world-class treatment as experienced by the participants of this study who completed their gender reassignment procedures prior to 1994. Instead, a study by Cairns and De Villiers (1980) presented various case studies in an attempt to showcase best practice in South Africa on gender realignment surgery. These case studies included procedures used and recommendations for surgeons (Cairns & De Villiers, 1980). Only positive outcomes were reported on, with very little or no unsuccessful cases. There were various concerns with regard to this article, including the unnecessarily graphic pictures of the women.

This evidence leads me to believe that the care which transsexual women received between the 1960s and 1990s was not done to assist transsexual women to have their physical embodiment realigned to their gender identity, but was merely a means for surgeons to practice their surgical skills and the transsexual women were used as subjects. Even though transsexual women received care and assistance under the apartheid government which assisted selected women to fully express their gender identity, this was done under a blanket of secrecy, which in turn oppressed the women who could not gain this access and silenced the women who had the treatment.

With the advent of democracy in 1994 the oppressive laws of the country were abolished and replaced by the new Constitution in 1996. This radically democratic and inclusive Constitution protects the rights of all people, including transsexual women. Under this legislation the identity, bodily integrity and choice of expression of trans women stands protected (Constitution of the Republic of South Africa [No. 108 of 1996], 1997).

Findings revealed that only two of the participants could manage to legally change their name and birth sex on the Population Register which could award them identity documentation reflecting their gender identity. They also reported a struggle with the Department of Home Affairs system, which seems at times unwilling to assist them with this change.

Having identity documentation congruent to your gender identity is one of the key liberating factors for transsexual women at any part of their transition journey. This would give her access to meaningful employment in the gender in which she feels comfortable. Being able to exercise such a right could award her economic freedom. She will also be able to apply for travel documents which will allow her freedom of movement. It would also award transsexual women the right to get married under the Marriage Act of South Africa. At the core of having suitable identity documentation is the fact that the transsexual woman is recognised as a woman, a human being. Being legally recognised as a woman, transsexual women will have access to female wards in hospitals and even being detained as a female prisoner, without being questioned. These measures all protect the safety of transsexual women.

The change of a transsexual woman's name and gender is done under the Alteration of Sex Description and Sex Status Act, which is in itself a liberating piece of legislation for transsexual women (Alteration of Sex Description and Sex Status Act, No. 49 of 2003, 2004). Under this Act transsexual women are allowed to apply for a change in their sex as listed on the Population Register. This will result in them attaining identity documentation congruent with their gender identity. In order for transsexual women to be eligible to have their birth sex changed, they would need to submit their Birth Certificate and a report from a medical practitioner (who could be a nurse or doctor) explaining that the woman is a transsexual woman and obtaining treatment to affirm her physical embodiment to her gender identity.

The immediate question one would ask is, in the light of the available legislation and the fact that identity documentation congruent to gender identity ensures protection, why do transsexual women struggle to claim this right? One of the participants in this study has been in transition since 1998, and even in 2014 she is still struggling to have her name changed on the Population Register. This wait can be put into context: South Africans have an average wait of six weeks to have their identity and travel documents processed through the Home Affairs system. To provide some insight into this problem is the voice of another participant, who has also been on the transition journey for a number of years without any success in changing her gender on the Population Register:

You go there, you go through a whole procedure. They want the letters and stuff from the doctor. You give it and stuff. You come here, they say no they can't change your name until the documents is there in front of them that it is not Caroline and this and that. And I mean why still go through this whole transformation. Half of your body is changed into totally being female, and then you come still here waiting for the ID, how long now, over 6 months, and there is always an issue. Come here then you still get degraded cause now you must be back on the male ... the born name, the one given by your parents. Walking in here with big breasts and being called that name, I mean, it is humiliating. Standing up in front of everybody, so why can't they have a personal link, that will be so much easier and less embarrassing.

When you start the treatment, you are changing, you are women and you need to get your ID sorted because you have now changed to a woman, but you must still deal with an ID that is male.

Why do we have such situations where transsexual women struggle to have their gender changed on the Population Register? Who are the role-players or gatekeepers in this process, and how does this impact on the physical and emotional health of transsexual women?

The legislation as it currently stands awards gate-keeping powers to medical practitioners and the Director General at the South African Department of Home Affairs. The Act allows transsexuals great scope as to who qualifies to have their gender changed. It includes women who are on hormonal treatment, women who have had surgery, and even women whose bodies have evolved naturally. In order to apply they would then only need the support of a medical practitioner and approval of the Director General.

This Act, however, does not include on which basis the medical practitioner or Director General can refuse support for a transsexual woman, and nowhere in the Act is mention made of penalties a medical practitioner or the Director General might face if they stand in the way of a woman who has grounds to apply for a change on the Population Register. Such inclusions would prevent practitioners and the Director General from refusing access to the rights of transsexual women, as seen in the Termination of Pregnancy Act whereby a practitioner who stands in the way of a lawful termination of pregnancy could be fined or even be given a jail sentence (Choice on Termination of Pregnancy Act, Act No. 92 of 1996, 1996).

I would say that these types of exclusions in our legislation allow officers of the State to enforce their power and prejudice to prevent transsexual women access to their rights. This fact leads to further oppression of an already marginalised community in our society by blocking access to economic freedom and preventing transsexual women from being recognised as a human being. These findings suggest that the “Giant” which I refer to in the master theme graphic (Figure 6.1) does not only manifest in the healthcare system as the medical practitioners, but remains present on all beaurocratic levels, preventing transsexual women from reaching organic womanhood.

Findings revealed an extremely long waiting period for transsexual women to have surgery in the public health sector. Some of them mentioned that it could take over 20 years for them to have gender reassignment surgery through the trans clinic operating at one of the tertiary hospitals in the Western Cape. This waiting period is so long that one of the participants commented that she would probably be dead when it is her turn:

“Some say ten years, some say 15 years, so honestly why make a decision now. I might be dead god forbid [laughter]. I mean, I am already 30, imagine If I should have surgery when I am 50. Do you understand?”

This sentiment is shared by other transsexual women who are waiting in line to have their lives changed – and they have no idea of exactly how long it will take. Having a body congruent to their gender identity almost becomes a dream which they feel might never turn into reality.

The long waiting period for gender reassignment surgery is confirmed by Bateman (2011), who reports that the trans clinic in the Western Cape is allowed theatre time to complete four gender reassignment procedures per year. Two are set aside for MTF surgery and two for FTM surgery. So for argument’s sake this would relate to a waiting period of 25 years should there be 50 MTF transsexual women on the waiting list. The rationale for the small amount of reassignment surgeries per year is attributed to budgetary constraints (Bateman, 2011).

Statistics from the World Bank (n.d.) state that South Africa spent 8.8% of its Gross Domestic Product (GDP) on the provision of healthcare during the time period 2009–2013. Half of this is spent on the provision of health care in the public service, whereas the other half is spent on private health care. Spending this amount of GDP on health care is quite a substantial

compared to the expenditure of neighbouring countries such as Zimbabwe, Angola and Mozambique, which all form part of the Southern African Development Community.

South Africa is committed to provide health care for all. This is demonstrated in the implementation of the National health Insurance (NHI). The key objectives of the NHI is to improve access to health care for all South Africans, manage risks in the system to towards equity and solidarity, ensure services are procured for the entire population, and to strengthen the public health system (Department of Health, 2011). Together with the implementation of the NHI, South Africa makes strategic provision to improve the health outcomes of women, reduce mortality due to non-communicable diseases, and improve the life expectancy of its people in the latest budget allocation for health care (National Treasury, 2014).

In a country where such great resources and strategies are in synergy to improve healthcare provision to its people, transsexual women should have adequate access to the healthcare services they deserve. However, in general the healthcare system of South Africa is in a struggle to adequately serve its population, despite the fact that it spends amounts for health care comparable to countries such as Thailand and Brazil, which show much better health outcomes than South Africa (Hofman & Tollman, 2010).

This long waiting period which transsexual women have to endure in order to receive surgical sexual realignment surgery translates into denial of necessary and timeous treatment for transsexual women. This contravenes section two of the South African Constitution, which states that: “everyone has the right to bodily and psychological integrity, which includes the right to security in, and control over their body”(Constitution of the Republic of South Africa [No. 108 of 1996], 1997).

This denial of necessary and timeous health care, which prevents transsexual women from receiving care, is demonstrated in this excerpt from one of the participants:

“The plastic surgeon, his personality when you go in there, his personality is stunning, but I can also see that maybe there is another party that is maybe dragging the process ... you understand? I can see that he tries to answer my questions, but he can't actually answer it, and he will stick to the answer that he only has four days and there is not enough funding.”

Although the standard answers given to transsexual women for the long waiting period – a lack of funding and available theatre time in the hospital – were often challenged by participants who were not convinced, evidence shows there is a lack of funding within the healthcare system to provide this treatment (Bateman, 2011). The findings revealed that participants are of the firm belief that there is another force that prevents willing practitioners from providing treatment and care to transsexual women. This could be a lack of political will within the healthcare system to assist transsexual women on their journey of sexual realignment.

South Africa is a country in possession of a Constitution which in itself is liberal and lends itself towards empowering all people. This inclusivity can also be observed in various other

pieces of legislation which governs the country. By itself, the legislation of South Africa ensures that transsexual women are protected, and they should have access to treatment options which will assist them on their journey of sexual realignment. However, the officers of the State, which include healthcare professionals and bureaucrats, still have power within the legislative framework to make conscious decisions on who receives care. Besides this power to block access to care which exists on a service delivery level, some healthcare practitioners might even be prevented from providing adequate care to transsexual women due to a lack of political will higher up in the South African political hierarchy.

7.5 Power in communication

Communication is at the heart of healthcare treatment. Healthcare practitioners and healthcare users will communicate with each other verbally and non-verbally. This interaction between provider and consumer might be seen as quite simple and clear-cut. However, findings reveal that the communication between transsexual women and healthcare practitioners shows a power imbalance, where the healthcare practitioner is perceived as the person who holds the power; hence whatever they say or omit to say must be deemed as important. This natural power which doctors in particular possess is based on the perception that they have an elevated social standing, have expert knowledge and can influence the health and behaviour of individuals and communities. It has been described as positional power, expert power, informational power, and coercive power (Gabel, 2012).

Opposed to the doctor who is viewed as the person who holds the power in the relationship, the healthcare user is perceived as a lay person without knowledge and thus having less power in this relationship. This power imbalance is strengthened even more when the healthcare user is of a lower socio-economic standing, and if she is a woman (Fochsen, Deshpande & Thorson, 2006). In transference of this fact, the assumption is made that there might be even greater power differences between doctors and transsexual women, as transsexual women have been proven to be marginalised with regard to their social, political and socio-economic status, and the mere fact that they are desperate to receive healthcare which will allow them to move from an in-between state towards organic womanhood.

Transsexual women in this study reported on the responses which they receive in the healthcare system. These responses could be widely categorised into two categories: responses they receive from support personnel such as admin clerks and cleaning staff, and responses which they receive from professional healthcare staff. In this part of the discussion I will focus on the responses which they receive from nurses and doctors. The reason for the choice is that it is the professional nurses and doctors who are trained and professionally certified to deliver health care to people, and they are the practitioners who are responsible for the health care provided in any healthcare institution by the support personnel. It is also the responsibility of the doctors and professional nurses to conduct assessments and diagnose and plan treatment for the healthcare user, while the support personnel will largely provide care on the instruction or request of these healthcare professionals. I will highlight

the responses transsexual women receive from healthcare professionals and discuss the impact these responses have on transsexual women.

When transsexual women enter the healthcare system for assistance with their gender realignment process, they might not have the necessary vocabulary or knowledge to explain the care which they need in order to have their physical bodies aligned to their gender identity. By no means does this imply that they are unaware of their needs. However, from the responses of doctors it might seem that the decision of sexual realignment lies with the doctor and not the transsexual woman:

"I started in the beginning of 2011. After I saw the doctors a couple of times, they told me that they are happy with me now and then they started me on the hormones.

"He will decide if you've had enough evaluation or not."

One of the participants made this statement when she was describing her initiation on feminising hormones. This statement clearly demonstrates the power imbalance which exists between healthcare practitioner and healthcare user. The transsexual woman came to see the doctor to assist her with her transition, yet the decision is with the doctor in the fact that he will treat her only when he is "happy" with her. What would have happened if he was unhappy with her? What constitutes this happiness or unhappiness of the doctor?

The National Health Act (No. 61 of 2003) is clear on participation in decisions which pertain to the health care of an individual. The user has the right to participate in the decision making when it comes to treatments or procedures (National Health Act [No.61 of 2003], 2004). Initiating hormone therapy for transsexual women should be a joint decision made by the healthcare provider and the transsexual women, in which they explore the best option for treatment for her that will yield the maximum benefit with the minimum risks. It is not merely a process whereby the practitioner will decide on initiating treatment based on his/her 'happiness'.

Even though transsexual woman might lack the necessary vocabulary and knowledge with regard to her needs, she is deemed the specialist of her own body as she has the experience of living in a body incongruent to her gender identity for her entire life. In order for doctors to fully understand the context of transsexual women, they would have to let go of some of their power in order to understand the experience of a transsexual foreign to himself (Strickler, 2009). It is therefore imperative that healthcare providers approach transsexual women in an empathetic manner and as far as possible prescribe acceptable treatment.

This subtle (or sometimes unsubtle) display of power by healthcare practitioners has a grave impact on how transsexual women interact with the healthcare system. It could lead to transsexual women feeling more disempowered, and it might even make them despondent to seek treatment from healthcare professionals, as data revealed.

One of the participants felt so strongly about the power which healthcare professionals hold that she told the plastic surgeon that he is just a doctor, he is not God and should stop playing

God. This statement indicates her anger towards doctors, who she perceives as people who can make the ultimate decisions of her life; hence the metaphor “playing God” is used. Another participant reported that she would borrow money from a friend or even make a loan to go and see a private practitioner who understands her situation rather than attending a government clinic when she suffers a health problem.

The social authority which doctors possess is often misused, owing to the fact that doctors believe that they have all the knowledge and patients have to blindly trust their expert opinion, and this is supported by literature (Fochsen, Deshpande & Thorson, 2006; Goodyear-Smith & Buetow, 2001).

As with the rest of the population, the level of emancipation varies among transsexual women, and they might attempt to negotiate care in a more assertive manner. The findings revealed that some of the transsexual women do attempt to negotiate the terms of their treatment with health practitioners. However, health practitioners often refuse to accommodate reasonable requests made by transsexual women, which will maintain the power within the hands of the health practitioners. For instance, one of the participants is a full-time student, holds down a second job and lives in a peri-urban area about 50 kilometres away from the trans clinic. Initially she tried to have her medication dispensed at the local primary healthcare (PHC) clinic, but was unsuccessful because the clinic refused to help her. The reasons they gave her is the fact that they do not dispense female medication to male clients. She was forced to go for her follow-up treatments at the trans clinic, and to have her medication dispensed at their pharmacy. She would only have a consultation with the doctor on a six-monthly basis, and would receive her monthly dose of medication. Travelling to the clinic on a monthly basis proved to be problematic for the participant as she would miss class and work, and she feared for her safety while taking public transport to get to the clinic. She requested the doctor to furnish her with a chronic private script for her medication, which she would pay for and collect at a local pharmacy, while she would still attend the clinic on a six-monthly basis. The doctor just refused without any explanation.

Such incidents strengthen the assumption even more that the planning of health care and treatment of transsexual women is not a participatory process between the health practitioner and the transsexual women. The healthcare practitioner will make decisions on behalf of transsexual women and would sometimes disregard their circumstances, and even neglect to give them the necessary information and justifications for their decisions. Should the doctor have honoured the request of the transsexual women, he would have undoubtedly handed over power. Sharing of power between doctors and patients would leave doctors insecure – he could feel that it is an insult to his superiority.

Doctors have the responsibility to assess clients and to prescribe and manage appropriate treatment. During the journey of sexual realignment transsexual women will be engaging with endocrinologists and plastic surgeons to manage their physical transition. In the public healthcare sector clients would often see different doctors, depending on which firm was working. There is also a high turnover of doctors within the public healthcare system due to

attrition, promotion and movement through the academic hospitals on rotation during their specialisation. Doctors would thus have to rely on the notes made in the folders of the clients which they are assigned, to get the case history and further the treatment and monitoring of the client.

Transsexual women experience the rotation of service providers as traumatic, and reported that they experience a feeling of broken confidentiality. This might not be the case, as their information remains private, but the feeling still remains with the women. Looking closer at this phenomenon of broken confidentiality, rotating care providers might not be the only contributor to this perception; the responses transsexual women receive from the different providers might be an aggravating factor.

The following data revealed some of the responses of doctors:

***Caroline:** "What I have discovered at the endocrine clinic is, I think most of the time it is ... Some of them find it humorous, because the look on their faces ..."*

***Brenda:** "Ja, it's this kind of, you can describe it as an awkward moment [laughter] when you are sort of with the doctor and he is kind of hesitant, especially with a male doctor that is examining you hmmm, he didn't check your folder. I made a point of it on the folder to have my details changed to make it reflect my name and my sex. And in many instances when I have spoken to a doctor out of the endocrine clinic and [he] looks at my folder and looks at me, he looks confused. It would be uncomfortable. With most I have found that they were professional and with a few, I think it has happened with me once or twice, where they were direct and would ask if you are transsexual [softly]. One was so blunt to ask if you are actually a man."*

***Caroline:** "To be honest, I don't mean to be rude, but I am pissed already. It's ... I mean I sometimes feel like, It feels like a big joke to me. Or I actually think they think it's a big joke to explain the same story over and over and over, I mean why they are taking notes when you are in there? Can't you just go through my file?"*

In the abovementioned, the responses from doctors were both verbal and non-verbal. I would describe these responses as being inquisitive, bordering on some type of voyeurism. It might be that the questions the doctors are asking these women might be because they could be genuinely uninformed, or did not have the time to go through the history of the patient before the consultation. It could also be the case that the doctor would want to verify the history in the folder written by his/her colleague who saw the patient previously.

Understanding that the healthcare system is under pressure and that there is a high turnover of staff, doctors should be aware of the fact that transsexual women are marginalised people and are sensitive to the responses of doctors. The recommendation would be that transsexual women would ideally see one care provider in order to build a relationship of trust between the doctor and the patient. If this is not possible, and rotation of doctors has to happen, doctors should be sensitised with regard to their verbal and non-verbal responses to their transsexual clients.

Within the literature it is well documented that even in our current post-racial society, bias and prejudice exist between doctors and healthcare users of minority groups (Chapman, Kaatz & Carnes, 2013; Levine & Ambady, 2013; McKinley, 2013). These studies have been done on white doctors and black patients, but in transference to transsexual women, who are a minority in the healthcare system, bias and prejudice towards them is also in existence. Most of the time bias, prejudice and judgement from doctors are seen in an indirect manner. Findings revealed that treatment would be delayed, or access denied to the transsexual client. In some cases transsexual women can easily pick up on the non-verbal cues of doctors when they are biased or prejudiced towards them. It does also happen, however, that healthcare practitioners verbalise trans-phobia while they are in consultation with transsexual women. One participant reported that a doctor at the hospital asked her why she was not happy with her body, and why can she not be a man seeing that society has few men.

Such a statement by a doctor could be viewed as a direct questioning of the transsexual women's gender identity. Such responses are a direct infringement of the woman's constitution right whereby no person may discriminate against a person's sexual orientation or gender identity (Constitution of the Republic of South Africa [No. 108 of 1996], 1997). This type of conduct is deemed punishable by law, and cannot ever be tolerated within the healthcare system.

In knowing that transsexual women are at risk for mental ill-health and have a high risk of committing suicide, such responses might make them feel that there is something fundamentally wrong with them as a human being. This could have an impact on their mental well-being and even slow the progress of their transition.

One of the other participants in the study made the comment that she does not want to be a mistake, as she is already a mistake. This comment was made when she spoke about her options for surgery, and she is afraid of the complications which might arise; however, she ended the sentence by acknowledging that she is already a mistake. When doctors respond insensitively to transsexual women they could strengthen this negative feeling of being a mistake.

I have discussed the verbal and non-verbal responses doctors make to transsexual women, and the impact they might have on them. I have also displayed that there is a power imbalance between the healthcare provider and the transsexual woman when they are together in the healthcare system to manage her sexual realignment journey.

Findings revealed another different power which exists in the relationship between the doctor and the transsexual woman – the power of silence. Silence was used by healthcare practitioners in various manners to oppress transsexual women, while preventing them from becoming emancipated in claiming their autonomy over their own health care. When healthcare practitioners withhold information from their clients they maintain their power position, in particular their power of information or expert power (Gabel, 2012; Fainzang, 2002; Goodyear-Smith & Buetow, 2001).

Doctors remain silent with regard to certain issues to protect the well-being of their patients, but in the case of transsexual women this can also be viewed as an abuse of their expert power in order to keep the transsexual women uninformed with doctors therefore maintaining their power in the relationship.

There is a movement in health care towards preventative health care instead of curative health care. This movement has been evident for as long as doctors have been taking the Hippocratic Oath when they complete their medical training. More recently in South Africa we are embarking on implementation of the NHI system. The NHI is based on providing affordable, acceptable, quality health care for all people in the country. The NHI also envisions that the greatest focus of health care should be on preventative health rather than curative health (Department of Health, 2011).

In order for such a system to function optimally, the healthcare users should ideally be informed about their own health status, and they should be able to find strategies to maintain their own health in order to prevent them from ending up in the curative health system for preventable health problems. This basic right which patients have is articulated in the Patients' Rights Charter, and it would be the responsibility of the healthcare provider to develop transsexual women up to a level where they have ample information with regard to their own health and will be able to make informed decisions (National Department of Health, 2014).

Health education lies at the core of this vision of equipping healthcare users to become autonomous when it comes to their own health. With proper health education, transsexual women will be able to identify possible side-effects of treatment promptly, and will be able to seek help when needed. They will also understand the changes which the hormones will facilitate in their bodies, and this could prevent some of the anxiety they experience when these changes occur. If they are aware of the possible changes in their mental health related to the use of feminising hormones, they can be vigilant should there be a decline in their mental health status and report such changes before this becomes critical. Generally transsexual women will become more emancipated with regard to their own health and the transition phase if they are equipped with adequate knowledge.

Such a shift would need doctors to take the necessary time to explain all procedures and processes in detail to the transsexual client when they are being consulted. It would also require doctors to spend more time with transsexual women to answer their questions. In equipping transsexual women with knowledge, the power dynamic between the doctor and the transsexual woman would become more balanced. However, in this study the transsexual women reported that they do not receive adequate health information or experience a complete absence of health education, which leads them to feel disempowered.

Providing health education and equipping transsexual women with the knowledge to manage their health is one of the basic functions of a doctor or any other healthcare practitioner. From the participants' voices it is clear that they do not receive adequate health information from the doctors who are monitoring their progress of transition.

The South African healthcare system is underresourced and doctors have a large patient load and do not have the time to spend with transsexual women to give them adequate health information. Such an assumption would be counter-intuitive, as doctors are trained to know that should their clients be equipped with knowledge, they would be better able to manage their own health, which will result in fewer consultations and in turn assist in lowering their patient load in the long term.

The findings suggest that doctors are not necessarily well enough equipped to assist transsexual women on their journey of transition. They themselves could be unsure of all the information which they have to give to the transsexual clients. This phenomenon is described in the literature as referent power. Doctors might be too afraid to refer clients when they themselves are unsure, but will mobilise tactics such as silence in order to maintain their social integrity (Gabel, 2012). Furthermore, they could hold back some of the information which they can give to the transsexual clients. They could be aware that should they equip transsexual women with information, they will ultimately start claiming their power in the system, and the doctor himself might not be ready to work with emancipated transsexual women claiming the health care which they deserve.

The findings revealed that transsexual women feel unimportant; they feel less human, almost like some form of project. Doctors are there to prescribe the treatment which will transform their embodiment, but never seem to get adequate information about the process from the healthcare provider. This causes anxiety in transsexual women that have even become scared to seek help from a healthcare provider, or they might even omit to inform the doctor of changes in their health or treatments they are taking without the knowledge of the doctor (Fainzang, 2002). Being scared to seek help from a healthcare provider or being afraid to be honest to the doctor perpetuates the power imbalance which exists between healthcare professional and transsexual woman.

This would leave transsexual women to rely on the information which they receive from their peers. The transsexual community is very small, and most will seek health care for their transition from the same healthcare providers who are working in the dedicated trans clinic. It can thus be surmised that they do not get the information which they possess and share from the healthcare providers at the clinic. It is unclear where they get the health information which they share with each other. This information could be unreliable or even detrimental to their health if they have sourced incorrect information and it is being shared among the trans community. The information which would be available to transsexual women would largely be sourced online. Online sources of information might not always be reliable, as they are generally not peer-reviewed (Weaver, 2012). It is therefore of utmost importance that transsexual women are equipped with accurate information with regard to their health in order to equip them in managing their own health.

As stated previously, the duty of the healthcare professional is to assess, diagnose and prescribe, and manage the treatment of their clients. In South Africa there is an overlap between the scope of the professional nurse and the scope of the doctor. The scope of the

doctor would pivot more towards the diagnostic and assessment side of the management of transsexual women, while that of the nurse would pivot more towards the management of treatment.

It is for this reason that I intentionally discuss the responses transsexual women receive from nurses separate from those from doctors. The core of nursing is to care, support and promote the health and well-being of the client. The healthcare user will also spend most of his time in the presence of a nurse rather than a doctor. The nurse would thus be the key person who would be able to monitor, support and promote the health and well-being of transsexual women who are on the journey of sexual realignment.

During the interviews I would ask participants about the responses they received from healthcare workers. This question included all people who worked in the healthcare system. What I found interesting was the fact that the participants would easily comment on the responses of the doctors and of the support staff, but the role of the nurse remained largely unremarked throughout all the interviews I conducted. I found this surprising, as the first contact the participants would have had before seeing a doctor would have been with a nurse.

One of the participants commented on the friendly conduct of nurses:

"Uhhh, well the nurses are quite friendly, like I said they are also very sensitive not to offend you. The conversations that they have are friendly you know. They stay away from anything that would seem discriminatory and uhhh and it is something that I appreciate, but coming to the endocrine clinic, you see the nurse for a short while. They take your folder and you get weighed and they take your bloods. So it is minimal contact with the nurses, but we do have these friendly conversations."

Findings revealed that nurses ensure minimal contact between themselves and transsexual women. The conversations are light and friendly and they stay away from having deep and intense conversations with transsexual women. This rings an alarm, because of the fact that there are missed opportunities in the time spent between the transsexual women and the nurse. As a health promoter it is the duty of the nurse to provide health education to his clients (Regulations Relating to the Scope of Practice of Persons Who are Registered or Enrolled under the Nursing Act, 1978, 1978). The time should also be used to make accurate assessments which could assist the doctor in making an accurate diagnosis.

The question remains as to why nurses would ensure minimal interaction between themselves and transsexual women. Findings revealed that transsexual women believe that nurses are uninformed with regard to the treatment and management of transsexual clients, and are not well-equipped enough to provide appropriate health information to transsexual women. By ensuring minimal contact with transsexual clients, nurses would maintain the power relationship and protect their own insecurity. Literature validates the finding that nurses will avoid contact with patients when they are unsure in a situation, such as working with clients with different ethnic backgrounds (Debesay et al., 2014).

The participants in this study clearly identified that nurses are not equipped with enough knowledge to firstly understand the phenomenon of transsexual women, and secondly to adequately treat and support transsexual women who are on the journey of sexual realignment. When the participants were asked what could be done to improve health services, they all mentioned that the training that nurses receive prepared them insufficiently to work with transsexual clients and that they need more training.

Besides the specific training which professional nurses need, they are adequately trained in the art of caring and being supportive to all people. They are compelled to promote the health of their clients and to keep all client information confidential. These core principles of caring are not only stated in the nurse's pledge, but also in the Nursing Act of South Africa which governs the practice of nurses. However, in practice the situation is different when nurses treat transsexual women. Transsexual women are treated as second-class citizens and generally treated with disdain:

"I dress down, but in the beginning the nurses would also ask: 'What are you doing here? Are you coming for this?'"

"And they will come in and then they pick up the folder and then they will look at you and call their colleagues and it is now a big joke."

As in the case with the doctors, the same type of inquisitiveness bordering on voyeurism is present in the nurses who treat transsexual women. This type of behaviour can easily break the relationship of trust between nurse and patient which is important to facilitate care. One of the participants went so far as to state that nurses are uncouth and rude, and that they have no bedside manner at all.

This cannot be the general state of nursing, and it would be impossible to generalise such a statement across the board to all care rendered by nurses. The question which arises is why this type of attitude and behaviour is present in nurses when they are tasked to render care to transsexual women? Could this be an indication that nurses are prejudiced and biased towards transsexual women, and thus displaying transphobic behaviour?

7.6 Clarifying assumptions held in this study

At the onset of this study, as the researcher and an advocate for the rights and health of the transsexual community in South Africa, I made various assumptions about the life-world of transsexual women and their journey of sexual realignment. These assumptions were based on the literature which I reviewed and my practical experience of being a healthcare professional and an advocate devoting time to work within the transsexual community.

The current available literature mainly stem from the west and there are few examples of literature on transsexual women which are written on African soil. It was thus difficult to transfer the knowledge of the west into Africa, where the context is so different. The west is concerned with issues of identity, HIV prevention and management, and finding the best

surgical techniques to realign the embodiments of transsexual women. In Africa, as a continent which is still on a developing trajectory, we are still dealing with issues of accepting the phenomenon of transsexuality as African, and various bread and butter issues such as social security and legislation.

In working with transsexual women on various platforms, I found inconsistencies between their African experiences and the available literature. In informal conversations held with transsexual women, they would often tell me about the struggles they have with changing their official identity documentation, their subsequent struggles to find formal employment and issues with the healthcare system.

This led me to formulate the following assumptions about transsexual women at the beginning of this study:

- The gender realignment process is not finite. When a transsexual woman embarks on the process of gender realignment, she enters a continuum which will last until the end of her life.
- The legislative processes of South Africa do not protect the health and rights of transsexual women.
- The current healthcare system is not ready to provide a holistic healthcare service to transsexual women seeking care for their gender realignment treatment.
- Transsexual women are uninformed with regard to their own health and therefore do not have enough knowledge to claim the health care which they deserve within the healthcare system.
- Transsexual women are a marginalised people.

I therefore presumed that using in-depth interviews as a data collection strategy, with a sample of ten transsexual women of rural, peri-urban and urban descent, I could gather rich data from the participants that would shed light on their life-world of living as a transsexual woman. The guidance of the analysis process for IPA assisted me as the researcher to make sense of the experiences of the transsexual women, as they are in a sense making progress in their own journey. Through this research report I am now able to verify and elaborate on the assumptions which were held at the onset of this study.

7.6.1 The gender realignment journey is not a finite process

The assumption that transsexual women will remain on a gender continuum once they have started gender realignment treatment proved to be false in this study. Transsexual women identify as women even before they embark on the journey of sexual realignment, and should be accepted as women. The confusion arises when they have started to alter their physical embodiment.

As found in the data, transsexual women will be in a state of confusion when they become aware of the changes in their bodies when feminising hormones start to change their secondary sexual characteristics. As mentioned by some of the participants, this process could be closely correlated to the process of adolescence when a girl starts to develop into a

woman during her years of puberty. If this confusion which transsexual women experience after initiation of feminising hormones is compared to puberty and adolescence in cisgender women, these feelings are deemed normal.

Taking the analogy of puberty in cisgender women even further and comparing it to the journey of transsexual women, it is safe to say that the process of puberty is considered final when women reach the age of about 18-21 years. At this time the secondary sexual characteristics of cisgender women are complete, and they can continue living their adult life as woman.

It is exactly at this point where the initial question arose as to whether the journey for transsexual women is finite or not. At the time I was of the opinion that the process could not be final because transsexual women would have to be on lifelong feminising hormones to maintain their secondary female characteristics. However, I have now come to the understanding that the realignment journey would be exactly the same as for the cisgender woman during her adolescent phase.

However, what this research has uncovered is the fact that transsexual women in the Western Cape struggle to have their bodies realigned due to poor access in the healthcare system to surgical sexual realignment services, thus leaving them in a space where they are in-between embodiments and cannot continue their lives as women. This not only has an impact on their mental health, but also on their social functioning as women. The women in this study who had their surgery completed as early as the 1970s did not refer to themselves as transsexual; they merely moved on and lived their lives as women.

In clarifying the gender identity of transsexual women, it would be an omission not to discuss their sexual orientation and sexual practice. Generally there is confusion with these three terms, and sometimes they are even used interchangeably.

With transsexual women identifying as women, they may also have various sexual orientations, as cisgender women would have. Transsexual women may be heterosexual women and would be romantically attracted to heterosexual men. They might be homosexual or lesbian women and could be attracted to lesbian women. Transsexual women could also be bisexual in that they will be romantically and physically attracted to both heterosexual men and lesbian women. Pansexuality is a fairly new concept describing the physical attraction of a person to any other person, disregarding their gender identity or sexual orientation.

In this study all the women who participated identified as heterosexual women. However, two of the women are in committed relationships which could be described as pansexual, as the one woman is in a relationship with another heterosexual woman and the other is in a relationship with a homosexual man.

Although this study never set out to explore the sexual practice of transsexual women, this information came out in a serendipitous manner. Transsexual women engage in various sexual activities and have to make various adaptations to their sexual repertoire to satisfy

themselves and their partners. It is noted that transsexual women would prefer to have penetrative vaginal sexual intercourse instead of penetrative anal intercourse, as they are of the opinion that penetrative anal intercourse is reserved for homosexual men. This was confirmed by international literature.

I can therefore affirm that transsexual women are women and that their realignment journey could be a finite one when they feel comfortable as a woman with the embodiment they are living in. However, this process is halted by the healthcare system, as there are not enough opportunities for transsexual women to have their physical embodiment realigned to their gender identity.

7.6.2 The legislative processes in South Africa do not protect transsexual women

South Africa can be described as young democracy. She was freed from apartheid governance with oppressive legislation in 1994. Unlike other African countries that were also bound by the shackles of colonialism, the power shift happened in a fairly smooth and peaceful manner, which resulted in the formation of a democratically elected government representing the voice of the people.

This change in governance resulted in South Africa having a Constitution which sets out to be inclusive, redressing the inequalities of the past and moving the country towards social justice. Guided by the Constitution of South Africa various Acts have been promulgated into law to protect the people of the country.

The particular Acts that were promulgated to protect the health and rights of transsexual women are the National Health Act and the Alteration of Sex Description and Sex Status Act. These two pieces of legislation are deemed to be progressive even for the western world. It should be noted that these Acts serve a country on a continent where trans-phobia and homophobia are condoned.

Even though these Acts have been in place for ten years, transsexual women find it difficult to claim their right to a name and bodily integrity while being protected by legislation. This led to the realisation that even with protective legislation, without the necessary political will and the dedication of civil servants to operationalise legislation to protect the health and rights of transsexual women, effecting social justice for transsexual women remains a challenge.

A concerning shift of conservatism in the political atmosphere is observed in South African governance. Recently the equality clause in the Constitution which forms the basis for the legislation that not only protects transsexual women, but all other people under the LGBTI umbrella, has been challenged. With newer legislation, such as that which governs the NHI system, issues of sexual minorities remain silent.

It is under this uncertainty of the legislative protection that I confirm that the current legislation and the implementation of such legislation does not adequately protect the health and well-being of transsexual women. Strategic activism is needed to ensure that the rights

and well-being of transsexual women and other sexual minorities remain on the political agenda.

7.6.3 The current healthcare system is not ready to provide a holistic healthcare service to transsexual women seeking care for their gender realignment treatment

The South African healthcare system of the past made provision for support and treatment of transsexual women, as revealed in this study. The context of this care remains sketchy, and I am unsure if these healthcare services were available to all transsexual women, and if the care that was offered was with the intention to assist and support transsexual women. With the advent of democracy in South Africa transsexual women were awarded the right to receive care and support to assist them on their journey of sexual realignment. However, the delivery of care at the patient level remains dysfunctional, even with the current attempts made by the healthcare system.

In a healthcare system with a primary healthcare focus, it is surprising that the care of transsexual women is seen as a tertiary health problem. The result of this is that the only space where dedicated sexual realignment care for transsexual women is located is at one academic hospital in the Western Cape, and one other academic hospital in the country. This means only two dedicated points of care in a country of 52 million people.

Having care only in specialist centres could add to the fact that the general population of healthcare workers is never granted the opportunity to manage and care for transsexual women. However, when transsexual women do enter the healthcare system for other health problems besides their sexual realignment, the healthcare providers do not seem to be adequately equipped to manage the care of the transsexual client.

The few care opportunities also make the service of sexual realignment unattainable for transsexual women who do not live in the Cape Town area. Rural women are practically excluded from receiving safe, adequate care for their sexual realignment under the supervision of a competent healthcare professional team. As uncovered in this study, rural women are left with two options. They could make use of the private healthcare system to assist them with their sexual realignment journey. This would need them to be of a higher socio-economic standing, due to the fact that they would only be assisted on a fee-for-service basis and medical insurance does not cover the cost of sexual realignment treatment. Their other option would be to find care off-code. This could be dangerous as these women would be left without adequate monitoring while being treated.

Not nearly enough space is available in the theatres for gender reassignment surgeries, as the current status quo of two sexual realignment surgeries per year for transsexual women is inadequate. The current waiting list is at least ten years long. Having such a long waiting period for surgery is unacceptable, as there are many transsexual women in the province who have started their sexual realignment process with the use of feminising hormones, but do not have access to surgical care to complete the process. This essentially leaves women who are in-between genders for an unknown time period. Women who live between genders are vulnerable to having poor mental health, it has an impact on their social functioning as it is

challenging for them to negotiate heterosexual relationships, and they are vulnerable to transphobic violence and hate crimes.

Healthcare providers, among whom I have only highlighted the doctor and the professional nurse, are not equipped to manage the health and well-being of transsexual clients. The practitioners who are working with transsexual women may have the knowledge of endocrinology and reconstructive surgery, but they also need to be sensitised to the context and lived experiences of transsexual women in order to provide sensitive, acceptable, quality care to their transsexual clients. Registered nurses are in need of receiving training with regard to transsexual health, ranging from the phenomenon of transsexualism up to the care and management of the transsexual client.

Currently transsexual women who do receive care for their sexual realignment seem to have access to assessment and initiation and management of feminising hormones. Furthermore, they have extremely limited access to surgical sexual realignment. There is a gap in the follow-up and support of transsexual women while they are on treatment with regard to their mental and social well-being. The treatment which transsexual women receive is medicalised, while a holistic health care package is absent.

The current healthcare system operates in silos of care where various specific healthcare programmes are presented (e.g. men's health, women's health, HIV care, tuberculosis care). Such programmes are designed from a heteronormative template, which leaves no space for people who identify beyond the socially accepted norm. On an operational level healthcare providers are unsure of where transsexual women should be treated. Should they be treated in a male ward under a men's programme, or in a female ward under a women's programme?

7.6.4 Transsexual women are uninformed with regard to their own health and therefore do not have enough knowledge to claim the health care which they deserve within the healthcare system

In order for any person to claim autonomy over their health and well-being, and to negotiate appropriate care in the healthcare system when the need arises, they would firstly have to have adequate knowledge with regard to the functioning of their bodies, and an awareness of their human rights. Looking from a cisgender perspective, such a statement might seem obvious. However, it is more complicated for transsexual women.

Cisgender individuals who are comfortable with their embodiment and who have grown up having harmony between their gender identity and physical embodiment will have a natural awareness with regard to the physiological functioning of their bodies. As a child parents, educators and healthcare professionals will teach you about your body and how it works. The media also plays a role in educating people on physiological functioning. This education happens by and large in an informal manner and is based on the presumption that the child is cisgender. During adolescence these same key players will take on an educational role in guiding and supporting the adolescent during the phase of rapid change occurring physically and psychologically.

The transsexual woman is reared as a male, and the informal education regarding their health would have been directed towards male health. As stated earlier, when the transsexual woman is initiated on feminising hormones she will enter a phase which can be compared to adolescence. She will have a rapid change in her physical appearance and emotional state. She would naturally be unprepared for these changes, as she would find it difficult to anticipate them without having the abovementioned “natural knowledge”.

Furthermore, the results of this study demonstrated that there is a vacuum with regard to appropriate health education received from healthcare professionals. The women in this study agreed that the healthcare information which they receive from healthcare professionals is either absent or inadequate for their needs. These women can, however, identify that they have a need to be educated with regard to their health care, so they rely on information from their peers or the internet. Being unsure about the reliability of the information which transsexual women have acquired leaves them feeling insecure and vulnerable.

I can confirm that transsexual women are not adequately prepared with regard to their health when they embark on the sexual realignment journey. This could prevent them from identifying health-related problems early, and seeking appropriate health care when needed.

7.6.5 Transsexual women are a marginalised people

The synonym for marginalisation is social exclusion. This is a process where individuals or groups are denied rights which the rest of the community enjoy, and are pushed towards the boundaries or periphery of the society.

Global literature confirms that transsexual women are a marginalised people. The literature goes further into levels of marginalisation, whereby it is documented that foreign-born, black transsexual women suffer a deeper level of marginalisation than their white counterparts.

In the South African context transsexual women are protected by means of legislation. However, transsexual women find it challenging to claim these rights in a conservative context where there are various gatekeepers who can prevent access to these rights.

Within the healthcare system of South Africa transsexual women do not have adequate access to assistance during their sexual realignment journey. The healthcare providers are not prepared to manage the health of transsexual women, with the result that they do not receive acceptable treatment and support within the healthcare system. They also do not have adequate knowledge to be able to claim their space in the system.

All of these factors contribute to transsexual women being disadvantaged and pushed to the margins of society because they find it difficult to function at a social, occupational, and economic level.

7.7 Conclusion

In this chapter I have crystallised the voices of the women who participated in this study by discussing aspects of the master theme graphic (Figure 6.1) which I developed grounded in the lived experiences of the transsexual women. This discussion was based on the collective voice of the participants. At the end of the chapter I clarified the assumptions which I held at the outset of this study, which I could either prove or disprove with the aid of the findings of this research and relevant literature.

The next chapter contains recommendations for research and practice based on the findings of this study, and the limitations which I identified are noted.

8.1 Introduction

This study is framed through a lens of trans-inclusive feminism. I have delved deeply into the experiences of transsexual women, making sense of their sense-making. This endeavour was undertaken not only to broaden my understanding of the phenomenon, but to assist healthcare providers to provide adequate, acceptable, quality health care to the transsexual community at the southernmost tip of Africa.

In this chapter I make appropriate recommendations for the healthcare system, policy maker, health education institution, activist and researcher, which are based on the findings of this study. I conclude chapter with acknowledgement of the limitations of this study.

8.2 Recommendations for the healthcare system

8.2.1 Manage transsexual women as women in the healthcare system

The findings of this study show that all of the participants self-identified as women. This is supported by a qualitative USA-based study describing the life experiences of transsexual women, where they found that transsexual women gravitate strongly towards the feminine and engage in feminine activities from a very young age (Brown et al., 2013). Therefore my recommendation is that the South African healthcare system should accept and identify transsexual women as women prior to and post-transition. They should be integrated into the women's health services and treated in the gender identity in which they feel comfortable. This would entail that transsexual women should be treated in female wards of hospitals and have documentation which refers to them in the feminine. Also, staff should always refer to transsexual women by using female pronouns.

8.2.2 Providing health care to transsexual women at the appropriate level

The findings of this study revealed that transsexual women experience difficulty in accessing appropriate health care to assist them with their journey of transition. Therefore it is my recommendation that transsexual women should be assisted with sexual realignment services at a community clinic level, and only referred for specialist care when needed. This will ensure better access to care for transsexual women.

The South African healthcare system is based on the principles of the primary healthcare approach. Broadly, such a healthcare system envisages health care to be affordable, acceptable, equitable and available to all. There is also a strong focus on preventative and promotive health care rather than curative health.

In line with the vision of the NHI system which is currently in its initial implementation phase in South Africa, the bulk of health care should be moved towards primary community

healthcare centres, while the tertiary and academic hospitals would only treat people on referral through the system should it not be possible to manage them at a more primary level.

If we view the sexual realignment care of transsexual women from a health perspective rather than an illness perspective, it is clear that initial assessment and treatment initiation of transsexual women should occur at a primary level instead of at a specialised tertiary clinic. This effort to move the care of transsexual women who are on the journey of sexual realignment towards a primary level of care will ensure access and affordability, which will greatly benefit transsexual women. The findings from this study showed that peri-urban and rural women find it difficult to access care to assist them with sexual realignment, as it is difficult for them to access the dedicated clinic for trans women based at the tertiary hospital in the city. This does, however, mean that transsexual women would inevitably have to be referred to tertiary hospitals for their surgical sexual realignment, but for the bulk of their treatment and monitoring they can be managed at a primary/community level.

8.2.3 Creating a functional multidisciplinary team for quality care of transsexual women

The care which transsexual women need in order to move to a state of organic womanhood can be achieved with the correct assessment, management, care and support from a devoted multidisciplinary team. A major identified cluster in this research found that practitioners are seen as gatekeepers to the care of transsexual women, and they do not function in synergy to assist transsexual women on their journey of sexual realignment. Therefore I advocate for the inclusion of transsexual health care in the general healthcare system, rather than seeing the care of transsexual women as a specialist need which requires a different, specialised multidisciplinary care team. The current available multidisciplinary healthcare team would be able to manage the care of the transsexual woman should they become more knowledgeable and sensitive to the needs of the transsexual woman. Incorporating the care of transsexual women into general health care will not only make the care more accessible to transsexual women, but it will also be more cost-effective to the healthcare system, as they do not have to set up specialised clinics caring for a small population. This measure will also combat stigma, as transsexual women would not have to be treated as 'special'.

The following healthcare practitioners would form the basic team to manage transsexual women who are on the journey of sexual realignment; the list is not by any means exhaustive:

- PHC nurse
- Mental health nurse
- Social worker
- Speech therapist
- Psychologist
- Psychiatrist
- General practitioner

- Endocrinologist
- Plastic and reconstructive surgeon.

8.2.3.1 *PHC nurse*

In South Africa the first point of care which most people will enter would be the PHC clinic. At this clinic the first healthcare professional which they would encounter would be the PHC nurse. The findings of this study found nurses to be either silent or ill-equipped to render care to transsexual women. Furthermore, participants reported on an absence of adequate health education. There is a need for a PHC nurse who can manage the transsexual client at a clinic level.

The PHC nurse should be able to firstly make an informed and adequate assessment of the situation of the transsexual woman requesting care. The nurse should also be able to identify clients who might request sexual realignment therapy, and he/she should educate the transsexual client on her options.

After the initial assessment it would be the duty of the PHC nurse to refer the transsexual client to the psychologist, social worker, and general practitioner to ensure that the assessment can be completed and the transsexual woman can be initiated on feminising hormones. Throughout the process of assessment and initiation of treatment the PHC nurse should support the transsexual client and ensure that she makes informed decisions with regard to her treatment.

The transsexual client will be on life-long treatment with feminising hormones. The dosages of the hormones might change according to her needs and general health status. It would be the PHC nurse who should take on the responsibility of monitoring the transsexual client's health and progress on a monthly basis while she is on treatment, and making appropriate referrals as she identifies the need. This function of the PHC nurse with regard to the treatment of the transsexual client is comparable to the care and treatment she renders to any other client who is treated with chronic medication at a PHC facility, such as the client who is being managed for hypertension.

8.2.3.2 *Mental health nurse*

The mental health nurse has a strategic role in the PHC system to ensure the mental health of the community, to identify clients who are in need of mental health intervention, and to rehabilitate mental health clients in the community. Mental wellness was a prominent cluster in this research, and it was found that transsexual women suffer from mental ill-health for various reasons. This has been confirmed by literature.

There is thus a need for active monitoring of transsexual clients with regard to their mental well-being. It is suggested that the mental health nurse in the community regularly assess the mental status of the transsexual client who is in the sexual realignment process. He/she should also offer support to the transsexual client throughout the process. Should the mental health nurse identify mental ill-health conditions such as depression in the transsexual client,

she should offer accepted therapies such as cognitive behavioural therapy, and make appropriate referral for further intervention and assistance. As with all other clients in the care of a mental health nurse, the approach to care should be affirming and non-judgemental.

8.2.3.3 *Social worker*

Findings from this research showed that transsexual women have difficulty with issues such as sexuality and their family unit, and adapting to their life with a changing physical body. The social worker is therefore needed to play a three-pronged role in the management of transsexual women who are on the journey of sexual realignment: an assessment role, a therapy role, and an education role.

With regard to assessment, it would be the duty of the social worker to assess not only the transsexual women but also the complete family situation in context. She will be able to draw up a needs assessment of the transsexual client and the family. This would assist her to formulate her management and in-depth reports which will be used by the rest of the team. Such reports can assist the team to have a better understanding of the context in which the transsexual client finds herself, assisting them to adapt their treatment and care to the context of the client.

The social worker should offer therapy to the transsexual client and the family. The therapy should have the goal of supporting the family and the transsexual client with the changes that she will experience, and how to accept the transsexual client within the family unit. The social worker would also be the key person to assist the transsexual client with the change in her registration at Home Affairs, and with employment as a woman.

The social worker also needs to provide education to the transsexual woman and her family about the process, their rights, and information on where to go for assistance should they feel that their rights are being denied in any manner.

8.2.3.4 *Speech therapist*

When transsexual women embark on the journey of sexual realignment, they will be initiated on feminising hormones which will cause their body to develop the secondary sexual characteristics of women. However, the hormones do not necessarily affect the tone of their male voice which they developed during adolescence. This was an observation which I made while spending eight months in the field with transsexual women.

The speech therapist needs to assist the transsexual woman to manage the tone of her voice to sound more feminine. This would assist her with her confidence levels in general.

8.2.3.5 *Psychologist*

Together with the mental health nurse, the psychologist forms part of the team of healthcare professionals with the main objective of maintaining the mental health of the transsexual women before, during, and after her transition. In the assessment phase the psychologist should assess the readiness of the transsexual woman for the process of sexual realignment.

Throughout the process the psychologist should rely on the reports of the social worker and the mental health nurse, and intervene with psychotherapy should the need arise.

8.2.3.6 *General practitioner*

Besides the general health needs of transsexual women, they also suffer side-effects related to the use of feminising hormones, as found in this research and supported by literature. They would therefore need to have access to a general medical practitioner. The general practitioner would be located at the PHC community level and should be available to the transsexual woman at all times. He/she will take on the role of the primary care giver for the treatment and management of transsexual women on the journey of sexual realignment.

It would be the responsibility of the general practitioner to closely monitor the progress of transition of the transsexual women, together with her general health and the impact of the hormones on her body. He/she will also manage the transsexual woman's general health, including her mental health, and make appropriate referrals to the rest of the multidisciplinary team when needed.

8.2.3.7 *Endocrinologist*

The endocrinologist would be one of the two specialists which the transsexual woman would have to be referred to at a higher level of care. It would be the responsibility of the endocrinologist to assess the health status of the transsexual woman, and to prescribe the appropriate feminising hormone regimen to the transsexual woman.

After he/she has completed the assessment and initiation of the hormone regimen the transsexual woman can be referred back to the primary level of care, where the team can monitor and manage the woman at a clinic level. The endocrinologist should be a support for the team working with the transsexual woman at clinic level, and be available to tend to the client should the clinic team need to refer her back to him/her at any stage.

8.2.3.8 *Plastic and reconstructive surgeon*

The hormonal realignment process should run concurrently with the surgical realignment process. Therefore it remains important that the transsexual woman consults with the reconstructive surgeon at the same time as the initiation of feminising hormones.

At the initial consultation with the reconstructive surgeon, the surgeon together with the transsexual woman should decide on which surgeries would be best suited to her needs. The findings of this study showed that reconstructive surgeons are vague with regard to the surgical process of realignment, and were seen as the person who holds the power. Therefore clear timelines for surgery should be set, and the surgeon should ensure not only the physical preparation of the client for major surgery, but their mental wellness throughout the realignment process.

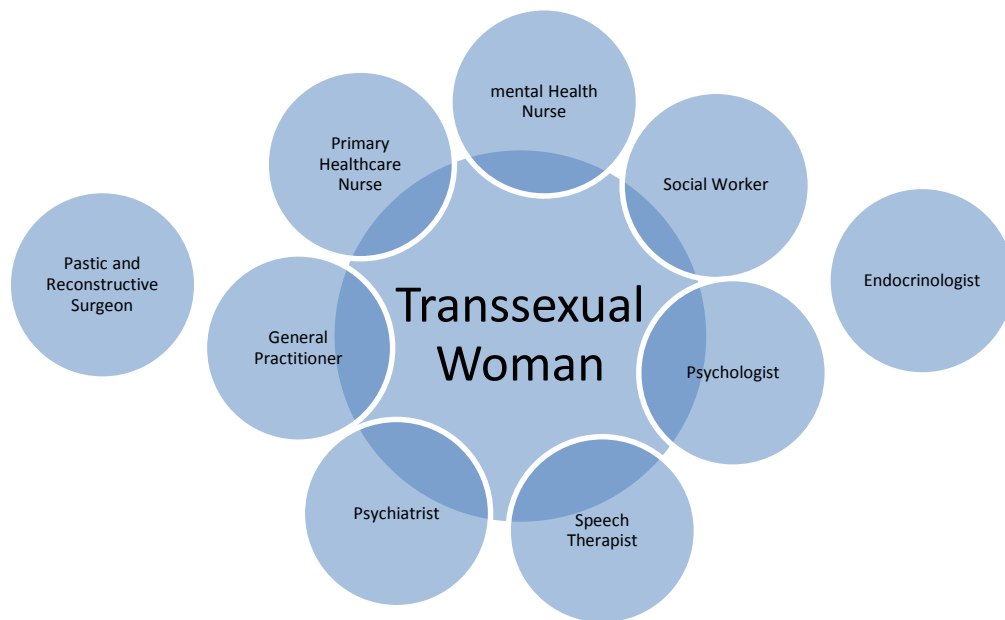


Figure 8.1. The ideal minimum make-up of the sexual realignment healthcare team to which every transsexual woman should have access.

This description of the functioning of a sexual realignment healthcare team should ideally be the minimum number of team members which the transsexual woman has access to. This functional team should communicate regularly on the progress of the clients in their care to ensure that the functioning in this team remains synergistic. It remains important that each member of the team has the best interests of the transsexual client as his/her objective, and they should make appropriate forward and backward referrals in order to use the strength of each team member to promote the health and well-being of the transsexual client who is on the journey of sexual realignment. This endeavour will ensure a swift realignment process which is accessible, acceptable and affordable to all transsexual women, and will ensure positive outcomes of the process as far as possible.

8.3 Recommendation for policy makers

8.3.1 Creating a trans-affirming healthcare system

Findings of this research revealed that transsexual women embrace womanhood and have the need to move from their current state towards that of organic womanhood. Transsexual women need the assistance of the healthcare system to assist them with their transition. However, the findings revealed that the healthcare system is seen as a giant with power preventing them from making the shift towards organic womanhood.

South Africa has legislation which protects the rights of transsexual women. However, there is a lack of health policy to ensure a trans-affirming healthcare system which will support

and protect transsexual women while they are on their journey towards organic womanhood. Figure 8.2 depicts the components of a trans-affirming healthcare system.

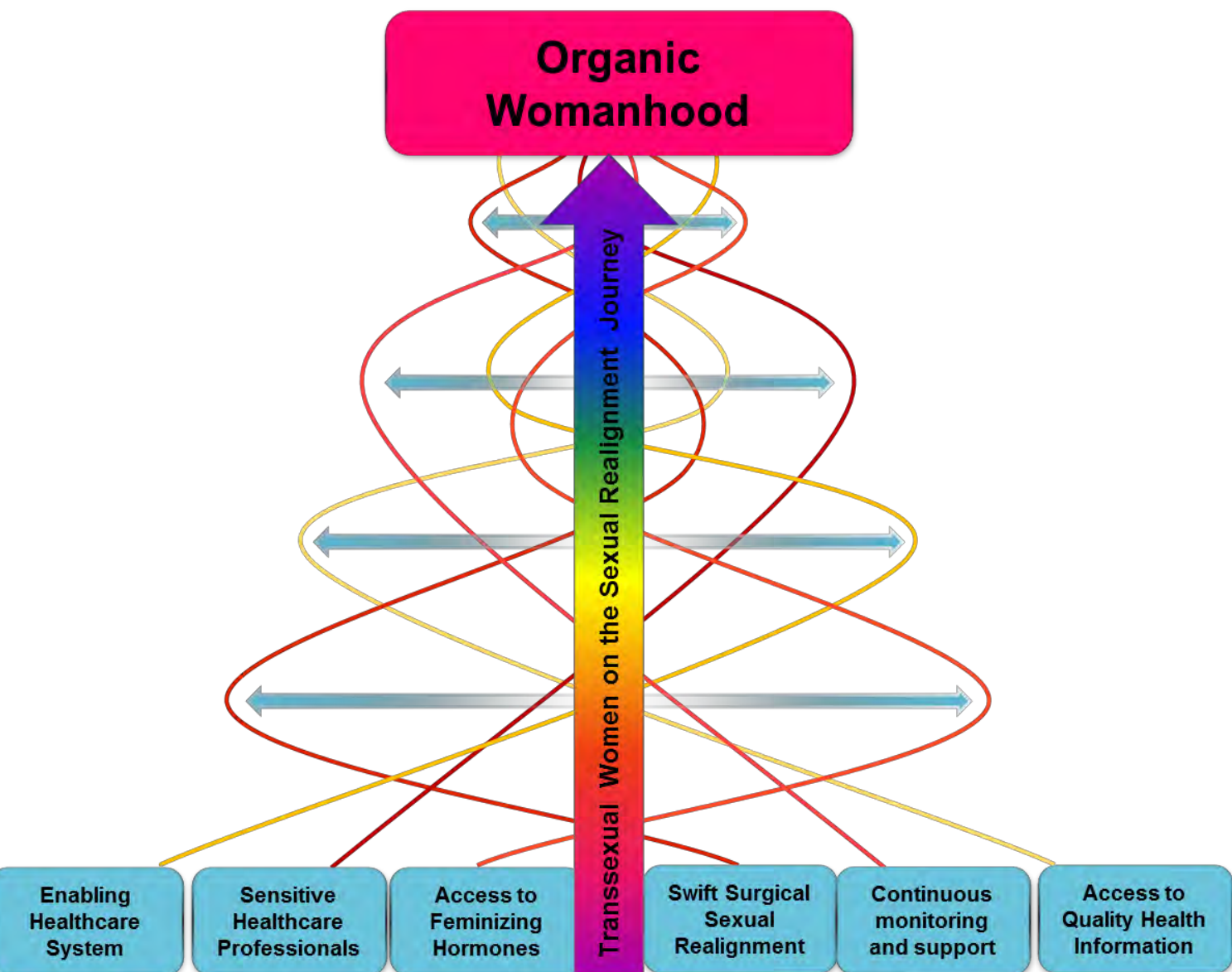


Figure 8.2. The components of a trans-affirming healthcare system.

The graphic above envisions a healthcare system which supports transsexual women on their journey of sexual realignment towards a state of organic womanhood. In Figure 8.2 the power imbalance which currently exists between the transsexual women and the healthcare system is equalised, as the healthcare system – which is made up of various components – is depicted at an equal level as the transsexual women when she enters the health system, while it works in a synergistic manner with the sole objective of moving the transsexual women towards the state of organic womanhood.

In order for this shift to take place to move transsexual women towards organic womanhood, transsexual women who enter the healthcare system would need the following: an enabling

healthcare system, sensitive healthcare professionals, access to feminising hormones, swift sexual realignment, continuous monitoring and support, and access to quality health information.

A healthcare system could be deemed enabling if it welcomes transsexual clients, has safe spaces for treatment available to these women at all levels of care, and support staff who treat transsexual clients with dignity and respect. Furthermore, transsexual women would have adequate access to the health professionals and facilities which they need to assist them on their sexual realignment journey, without being subjected to unnecessarily long waiting periods for appointments and procedures (which are longer than those for the general public).

Healthcare professionals will be sensitised to the needs of transsexual women and they will have adequate knowledge and skills to manage the health and well-being of their transsexual clients. They will also be able to appropriately identify when to refer the transsexual woman to the appropriate health professional who would be able to assist the woman on her journey.

Feminising hormones should be available to transsexual women at clinic level in the community where the woman resides. The feminising hormones should be dispensed to the transsexual woman by a pharmacist who is able to furnish her with the necessary health education and would be able to refer her should she present with any side-effects of treatment which need attention.

As soon as the transsexual woman has been initiated on feminising hormones, she should be referred to see a reconstructive surgeon who will assist her with the design of her surgical sexual realignment procedure options. She will have access to the necessary procedures with the minimum waiting period for surgery.

Continuous monitoring and support should be provided to the transsexual woman at clinic level throughout her journey of sexual realignment. The core team responsible for her monitoring and support would be the PHC nurse, the mental health nurse, the general practitioner, social worker and psychologist. The community-based healthcare team will not only monitor her physical progress with regard to her transition, but take care of her general and mental healthcare needs. This team will also assist the transsexual woman with her occupational and social functioning as a woman.

The complete multidisciplinary team will provide the transsexual woman with accurate, quality health education which will ensure that she will have enough knowledge of the functioning of her body to claim the necessary health care from the correct provider when needed.

8.4 Recommendations for health education institutions

8.4.1 Providing short courses on trans-health to practising healthcare practitioners

The care which transsexual women receive in the healthcare system was a prominent cluster in this research. Transsexual women are ill-treated, not seen as a priority, and even ignored in the healthcare system. They even fear transphobic attacks at government-funded healthcare institutions.

Although the healthcare system has the physical resources in place, such as the existing healthcare team, pharmacies with drugs, community health centres and referral hospitals, the healthcare providers are in need of a form of sensitisation training with regard to the treatment and management of transsexual women. The physical management in respect of the pharmacological and surgical management of transsexual women forms part of the training of healthcare professionals. However, the phenomenon of people with gender identities different to their physical embodiments does not routinely form part of the training of healthcare professionals. Therefore it is imperative that all healthcare providers should be adequately prepared with the necessary skills in order to manage the health and well-being of their transsexual clients.

The areas of training outlined below are recommended for all healthcare professionals who work with transsexual women who are on the journey of sexual realignment.

8.4.1.1 Gender Identity and Embodiments

Healthcare providers should understand the difference between gender identity, sexual orientation and sexual practice. Awareness needs to be created that a person's gender identity will not always be congruent with their physical embodiment. When healthcare providers are faced with a client who identifies as being transsexual, they should be aware of the different treatment options which they can offer to protect and promote their health.

8.4.1.2 Transsexual Women and Legislation

The health and well-being of transsexual women are protected by various pieces of legislation in South Africa. Healthcare providers should become aware of how the Constitution, the Health Act, and the Alteration of Sex Description and Sex Status Act should be utilised in order to promote and protect the health and well-being of transsexual women.

8.4.1.3 Hormonal and Surgical Options for Transsexual Women

The multidisciplinary team should be aware of the various hormonal and surgical options which are available to transsexual women who wish to have gender realignment treatment. It is also important for all healthcare providers to be aware of the possible side-effects and complications of treatment which may arise when a transsexual women is on treatment for sexual realignment. This would assist them to identify any problems which may occur

Health practitioners should also be guided towards literature which can assist them in the medical and surgical management of transsexual women. Some of the literature of importance would be the standards of care for transsexual women, and journal publications

such as *Sexualities*, which regularly publish the latest research on gender identity and sexuality.

8.4.1.4 *Communicating Health to Transsexual Women*

The women who participated in this research agreed that they do not receive adequate health education with regard to their health from the health professionals who treat them. Therefore health practitioners should be trained on how to communicate about health to their transsexual clients in order to empower them.

8.4.1.5 *Advocating Trans Health*

The healthcare practitioner should be the advocate for the health and rights of the transsexual client. They should also be able to create awareness among their colleagues about the issues affecting the health and well-being of transsexual women. Part of the development of healthcare professionals would be to motivate them to challenge the healthcare system, especially on the issue of swift surgical sexual realignment.

8.4.2 Including trans-health in healthcare education programmes

It is my recommendation that the undergraduate and postgraduate programmes of healthcare practitioners should include trans-health. The recommended focus areas would be similar to that of the recommended Short Course for Practising Healthcare Practitioners. This inclusion of trans-health in the undergraduate and postgraduate curricula will develop inclusive and affirming healthcare practitioners, which could contribute positively to a trans-affirming healthcare system.

8.5 Recommendation for activists

8.5.1 Removing the T from the LGBTI umbrella

Findings of this research revealed that transsexual women identify as heterosexual women. This is supported by studies conducted in Thailand and the USA (Ocha, 2012; Bischof et al., 2011).

This finding together with the literature adds to the debate that transsexual women should be removed from the umbrella term of LGBTI, as they do not exactly identify with the grouping as heterosexual women. This might also be one of the reasons why transsexual health and rights are not necessarily the focus among LGBTI activists.

8.6 Recommendations for further research

The purpose of this study was to understand the life-world of transsexual women in relation to their awareness of their unique health needs which occur as a direct result of their sexual realignment treatment and their health-seeking behaviours, practices and experiences of responses in negotiating health care for their transgender-related health needs. Through this study process I gained better insight into how transsexual women self-identify and experience health-related problems. I could also analyse their experiences with the healthcare system and practitioners while they are negotiating care to realign their physical embodiment

with their gender identity. Through this process I could identify possible further research which could add value to the research debate of transsexual people:

1. A longitudinal study of transsexual women who are in transition will be of value in order to follow the changes in their physical and psychological health before, during and after transition.
2. The experiences of FTM transsexual men within the healthcare system should be investigated. Transsexual men experience different side-effects related to their sexual realignment treatment. Furthermore, they have different issues of gender and power as they would enter the world of male privilege through their transition. The findings of such a study could be compared to those of this study.
3. Research based on a participatory action research model with an aim to develop models of care for transsexual women in Africa can be of great value. This research would include transsexual women and health practitioners, and could have a direct impact on the transsexual women and the healthcare practitioners who participate.

8.7 Study limitations

Through conducting this study I have identified limitations which need to be acknowledged:

1. South Africa consists of nine provinces. Although all provinces are governed by one national government, the context in each province varies due to geography, economy and political history. I therefore acknowledge the fact that only women from the Western Cape Province were included in this study was a limitation. However, I am convinced that the findings of this study can be transferred to other contexts in South Africa.
2. A possible limitation to this study was the fact that all the women which I sampled utilised the government-funded healthcare system to assist them with their gender realignment process. The experience of women who can afford to pay for their gender realignment services either within the South African private healthcare system or abroad might be totally different from those of the women included in this study. However, the women included in this study ranged from middle to lower socio-economic status, and could be viewed as being representative of the transsexual community as only a select few transsexual women would be able to afford private health care to assist them with sexual realignment. Such services remain out of reach for most transsexual women in South Africa.
3. The inclusion of only MTF transsexual women in the study could be seen as a limitation since FTM transsexual men were excluded. Although transsexual women and transsexual men both live with incongruent gender identities, the surgery and hormones which they use to assist them in gender realignment differ. I therefore made a conscious decision to exclude transsexual men from this study. However, I believe

that the findings of this study could be transferred and adapted to the context of transsexual men.

4. Transsexual women are oppressed and exist on the margins of the population. Therefore the fact that they are being investigated by a cisgender male, who might be seen as a person with power, could be seen as a limitation to this study. It might be questioned whether a man could fully understand the context of transsexual women and do justice to their voices. However, as an activist for the health and rights of transgender people, I believe that I could do justice to the voice of transsexual women and ensure that their experiences add value to the research debate.

8.8 Conclusion

In this chapter I made recommendations for practice and research. The recommendations for practice can be utilised by the healthcare system to provide quality, acceptable care for transsexual women who are on the journey of sexual realignment. These recommendations can move transsexual women from the vulnerable state of living with an incongruent body and gender identity towards organic womanhood. Furthermore, I made appropriate recommendations for research which could positively contribute an African voice to the transgender research debate. I ended the chapter with the limitations which I identified while conducting the study.

The last chapter of this report is used to evaluate the quality of this research project, and will assist the reader in identifying the strategies implemented to ensure quality qualitative research.

9.1 Introduction

It is common practice in the reporting of qualitative research to include the strategies implemented to ensure rigour in the study, which are usually presented early in the report. I have made a conscious decision to include the evaluation of the quality of this research project towards the end of the report in order to allow the reader to evaluate the strength of the strategies of rigour implemented in this research after he/she has consumed the reported project in its totality.

9.2 Rigour

Evaluating the quality of qualitative research has been widely discussed in the literature over the past three decades. While quantitative research has set criteria to assess validity and reliability, these are not sufficient to measure the quality of qualitative research due to the distinct differences between the two paradigms (Cutcliffe, McKenna & Cutcliffe, 1999). The standard criteria to ensure rigour in qualitative research which are often used by qualitative researchers are those described by Lincoln and Guba (1985), which include credibility, dependability, confirmability and transferability. Various other authors have attempted to describe measures in order to ensure rigour in qualitative research since then, but all make use of Lincoln and Guba's criteria as a blueprint, with various adaptations (Yin, 2011; Bourgeault, Dingwall & De Vries, 2010; Creswell, 2003, 2009; Maxwell, 1996).

In order to demonstrate the rigour of this study I have decided to present the quality of this project guided by the model developed by Tracy (2010). This model embraces the criteria, namely: worthy topic, rich rigour, sincerity, credibility, resonance, significant contribution, ethics, and meaningful coherence, in order to evaluate the quality of a qualitative research study. This model allows the researcher scope to demonstrate the quality of his study in an organised, accurate manner without the rigidity of other described criteria. This model has been described in the literature as being appropriate, universal and flexible (Gordon & Patterson, 2013).

9.2.1 Worthy topic

The topic of investigating the experiences of transsexual women in the healthcare system can be looked at as worthy from a political/human rights and academic perspective.

The current political atmosphere in Africa is moving towards conservatism, whereby stricter laws are being passed which condemn homosexuality. These laws can be seen as being Draconian in the sense that they go as far as to punish people who do not identify as heterosexual with the death penalty or a jail sentence. This movement can also be seen as an attempt to strengthen the belief that any sexuality other than heterosexuality is deemed un-African and should be frowned upon. This has an impact on the healthcare provision for

transsexual women. The more that this conservative school of thought spreads across Africa, the more difficult it will become for transsexual women to access appropriate care.

The South African situation might seem different, because transsexual women are protected under the Constitution of the country. However, South Africa forms part of Africa and the laws passed in other African countries cannot be ignored, since they do have an influence on the local context. For instance, healthcare workers from across the continent elect to practice in South Africa, and might bring their institutionalised trans-phobia with them and transpose it into the care which they provide in South Africa. Transsexual women across Africa live in fear of prosecution and will seek asylum in South Africa in order to be protected under the South African Constitution. This influx of regional transsexual women puts strain on a healthcare system that currently does not have the capacity to provide adequate, acceptable and quality care to transsexual women.

The body of research which pertains to transsexual women is slowly growing and making contributions to the global academic debate. However, the voice of African transsexual women in the academic debate remains silent. There is also a gap in the literature with regard to the role of the nurse in particular when it comes to the care and management of transsexual women.

I therefore believe that this topic is interesting, timely and significant in the current political and research atmosphere in Africa, in order to advocate appropriate, dignified treatment of transsexual women and to make a significant contribution to the academic debate.

9.2.2 Rich rigour

The detailed process of how exactly this study was conducted is clearly explained in this research report in order for the reader to fully understand the process which resulted in the discussion and recommendations. In order to demonstrate the rigour of this study, I will highlight aspects of the methodology.

A pilot study was conducted to validate the research instrument (myself) and to test if the questions in the interview guide could satisfy the objectives of the study. The pilot study also tested the sampling strategy and the analysis process. After conclusion of the pilot study amendments were made to the research plan to improve on the quality of the project.

The sample included in this study was achieved through purposive and snowball sampling techniques. The sample was eclectic as it included women from urban and rural settings, women with different social standing, and a mix of cultural and racial backgrounds. This eclectic sample adds to the rigour of the study as it covered the depth of experience of transsexual women from various circumstances.

In order for me as an outsider to understand the life-world of transsexual women I spent eight months in the field collecting data while conducting in-depth interviews, immersing myself in the realities and experiences of transsexual women. I collected and analysed the data until theoretical saturation was reached, and only then was I satisfied that the data collection process should be concluded.

Data were analysed according to the accepted steps set out by Smith (2010) to analyse data in an IPA study. This specific analysis process is widely accepted in the literature as a quality strategy in the analysis of qualitative data.

I am thus of the opinion that I have implemented quality strategies to ensure sufficient rigour in this research.

9.2.3 Sincerity

Throughout this research project I have endeavoured to conduct and report on this research in the most authentic manner possible. I have incorporated self-reflexivity and transparency in this research.

In Chapter two of this report, even before I started to introduce the literature to the reader, I was upfront about my biases with regard to this research project. I have also implemented bracketing and critical reflection as strategies to minimise the influence of undue bias on the participants, the data, analysis and reporting of the data. However, as a nurse and an activist for the health and rights of transsexual women, I believe that I could approach this research with the deserved sensitivity while reporting on the findings in an authentic manner.

9.2.4 Credibility

This research report is reported in the first voice, the voice of the researcher who was the main instrument utilised to gather the data for this study. However, there are more voices present in this report. Through the thick descriptions of the participants, as included in this report, the participants have been given a voice. The descriptions are sufficient to allow the reader to judge whether the interpretations made by the researcher are grounded within the voices of the participants. Great care has been taken to highlight the voice of each participant in this report and to allow them to “speak in synergy”.

Two sampling approaches were implemented in this research. Participants were recruited through purposive sampling and snowball sampling. This strategy to sampling yielded participants who were from rural, urban and peri-urban areas of the Western Cape. Besides the differences in geographical location, participants came from different socio-economic, ethnic and educational backgrounds. It can be said that there was triangulation of sampling methods and a heterogeneous sample of participants which yielded convergent results.

9.2.5 Resonance

According to Tracy (2010), in order to achieve resonance in a qualitative study the researcher should attempt to achieve aesthetic merit and transferability. These attempts are made to affect and reverberate with the audience in a meaningful manner.

In this the report I have made use of uncomplicated language in order to allow the data, and inevitably the voice of the participants, to come to the foreground while I merely moved their lived experiences to a level of interpretation. I consciously steered away from using unnecessary jargon in the report, and made every attempt to clarify any terminology which might be foreign to the reader. The report is clearly set out and the reader is systematically introduced to the problem, the process, and the results of this research.

As I stated in Chapter 8 of this report, the findings of this research cannot be generalised. However, the findings of this research can be transferred to health care of transsexual people seeking health care across South Africa.

9.2.6 Significant contribution

Qualitative research can be seen to make a significant contribution if it demonstrates theoretical, heuristic and practical significance among others (Tracy, 2010). This study is significant as it makes an impact on the following levels:

- This research gave a voice to hitherto rarely heard African transsexual women, which contributes to the transgender research debate.
- The practical recommendations can assist the healthcare system to improve the services which they offer to the transsexual community.
- The findings of this research demonstrate that even though transsexual women in South Africa are protected by various pieces of legislation, poor implementation and a lack of political will contribute to preventing transsexual women from becoming the organic women that they wish to be.

9.2.7 Ethics

As a researcher it is my duty to conduct ethically sound research. However, in this particular study, where the participants were from a marginalised community, I had to take extra care in ensuring that the phases in this research project were conducted with sufficient ethical consciousness.

Prior to the inception of this study a research proposal was presented to the postgraduate committee of the Department of Health and Rehabilitation Sciences of the University of Cape Town, where it was reviewed by senior qualitative researchers for scientific and ethical soundness. After the approval of the quality assurance committee, the research proposal was submitted to the Health Science Research and Ethics Committee of University of Cape Town. The proposal was reviewed by various members on the committee evaluating the proposed procedural ethical principles which I included. After they were satisfied with the ethical soundness of my proposed study, they granted me ethical clearance to conduct the study (Appendix I).

Besides the procedural ethics, which followed the guidelines of the World Medical Association, which I adhered to while conducting the study, various unexpected ethical issues arose during the data collection process. One such issue was the fact that the proposal clearly stated that the interviews would be conducted in the natural environment of the participant, which I assumed to be the home of the participant. It did however occur that participants informed me that they did not feel safe to have their interviews conducted in their homes, and I had to make a decision as to where the interviews would be carried out while still observing all the ethical guidelines. After reviewing the work of other researchers who conducted similar research in comparable contexts, I could confidently invite

participants to have their interviews conducted in the safety of my office and still observe all the ethical principles.

Power played an important role in this research project, as I was investigating women who are at a power disadvantage in the healthcare system and society in general. I had to be conscious of my power which I possess as a researcher and a healthcare practitioner, and had to ensure that I never exerted my power to such an extent that the participants felt that they were coerced into participating in this research. I strategically dressed down whenever I had any interaction with participants, and communicated with them in the language in which they felt most comfortable. I took my time with obtaining consent from the participants and made sure that they felt comfortable to participate in the study.

The ethical relationship between the participants and myself was not terminated after the data were collected. I have stated in this research that the transsexual community is a very small community, and that the community is extremely interconnected. The community of trans activists were aware of the research which I was conducting, and at various platforms where I have disseminated my findings, some of the participants of my study would be present. I had to ensure that they remained unidentifiable in the dissemination of my results, as they could be marginalised even further should they become identified through my research.

9.2.8 Meaningful coherence

Meaningful coherence in qualitative research is viewed in different ways, depending on who is reviewing the research. This report was prepared for presentation to examiners, and I have endeavoured to present it in a meaningfully coherent manner by presenting the following aspects in the report:

- The objectives of this study were clearly stated in the first chapter and were all satisfied through the presentation of the analysis, discussion and recommendations.
- The method of inquiry used in this research was found to be appropriate to answer the research question.
- Literature was appropriately used to support this research and to enhance the discussion of findings of this study.
- I ensured that the discussion and recommendations are grounded on the findings of this research.
- This report is structured in a logical manner.

9.3 Conclusion

This final chapter of this research report was dedicated to evaluating the quality of this research project. I have done this through applying modern criteria for evaluating qualitative research. Using this structured model not only assisted me as the researcher to ensure sufficient quality of this research, but will give the reader clarity on the strategies which I implemented to ensure rigour.

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APPENDICES

Appendix A: Information Sheet

I, Douglas Newman-Valentine, am currently studying towards a doctoral degree (PhD) at the University of Cape Town, Department of Health and Rehabilitation Science, Division of Nursing and Midwifery. I am conducting research to understand how aware transsexual women are of their unique health needs and how they go about seeking health care for their problems relating to sexual-realignment therapy. This type of research has never been done in Africa. Your participation may help to assist other transsexual women to identify their health needs and negotiate appropriate health care.

What is expected from your participation in the study?

Should you agree to participate in this study, I will meet with you once for an interview that will last for about 90 minutes. We will have the interview wherever you feel most comfortable, and at a time that will suit you best. I will ask you questions about your health and your experiences of visiting a clinic or hospital when you have had a problem with your health. The questions that I will ask will focus on your personal experience, and I might ask you to elaborate on your answers. An example of a question would be: *What have you done about your health problems?* This type of question is called an open-ended question. There are no right or wrong answers to the questions. Should you not understand any of the questions please do not hesitate to ask me to clarify any uncertainties. If you feel that any of the questions that I am asking are too personal, you may choose not to answer the particular question.

I will ask your permission to audio record our interview and I will be making notes while you are talking to me. The recording and the notes will help me to remember everything that you have told me. If you do not feel comfortable with the audio recording, I will not record our interview, but will only make notes.

When I have completed the analysis of our interview I will set up a follow up appointment with you to verify the information that you have given me.

What are the potential benefits?

There are no direct benefits to you in participating in this study; however your participation in this study will give you an opportunity to share your life experiences with me who endeavours to effect positive change in the lives of people who are undergoing similar changes to you. The information that you share will help me to compile a report that might benefit other transsexual women who are undergoing sexual-realignment therapy.

What are the potential risks?

There are no anticipated risks. However, there is a small chance that you may experience distress during the interview. Should you feel distress at any point during the interview, you should immediately inform me. We can reflect on your distress and postpone the interview until you feel that you are ready to continue. Should the distress persist, I will refer you for counselling. Trained counsellors affiliated with Gender Dynamix, an NGO that supports transsexual women, will provide counselling. Should you discontinue, there will be no negative consequences.

Confidentiality

The information that you share in our interview will be treated with confidentiality. Your real name will never be used in the analysis of the data and no one will ever be able to connect you to this research.

Voluntary participation

Participation in this study is voluntary and you may withdraw your participation from the study at any time without being disadvantaged.

Where do I find more information on this study?

If you need any more information about this study, or questions with regarding to your rights and welfare as research participants, you may contact the following people:

1. Associate Professor Sinegugu Duma

Research supervisor

Tel: 021 650 6428

E-mail: Sinegugu.duma@uct.ac.za

2. Professor Marc Blockman

Chairperson of the Faculty of Health Sciences Human Research Ethics Committee

Tel: 0214066496

E-mail: marc.blockman@uct.ac.za

What do I do if I wish to participate in the study?

If you agree to participate in this study, you will be requested to sign a consent form as evidence that you understand what the study is about and that you participate voluntarily.

Thank You

Douglas Newman-Valentine

Researcher

Tel: 021 650 6619

E-mail: douglas.newman-valentine@uct.ac.za

Appendix B: Informed Consent Document

Consent to Participate in the Study:

I (Name and Surname) have read the information with regard to this study attached to this document and I have clarified any uncertainties with the researcher. I understand the purpose of this study and my involvement.

By signing this consent form, I voluntarily agree to participate in this study.

My role will be:

1. To answer all the questions posed by the researcher during an interview session.
2. To ask the researcher for clarification if I do not understand something

Risks

Due to the fact that I will be sharing personal information with the researcher, I understand that I may feel distressed. Should this happen I will immediately inform the researcher. Together with the researcher, we will reflect on my distress and take the necessary action as explained in the information sheet.

Confidentiality

The researcher will handle all information that I share with him as confidential. My real name will never be used in any reports or publications arising from this research study.

Benefits

My participation in this study will give me an opportunity to share my life experiences with a researcher who endeavours to effect positive change in the lives of people who are undergoing similar changes like me. The information that I share will help the researcher to complete this study, and the results might benefit other transsexual women who are undergoing sexual-realignment therapy.

Voluntary participation

Participation in this study is voluntary and that I may withdraw from the study without being disadvantaged.

Participant

Researcher

Date:

Place:

Appendix C: English Interview Schedule

Interview Schedule: in-depth interviews

Briefing

You have been approached to participate in this study as your experiences can help me to understand important issues that affect your health needs and health services that you receive as a transsexual woman during your sexual-realignment process. The interview will last about one and a half hours. I will ask you a few questions. There is no right or wrong answers to the questions. Answer the questions to the best of your knowledge and please tell me if anything is unclear to you. Your answers will never be linked to your name.

Background Questions

1. Name:
2. Age:
3. Highest level of education:
4. Are you using any medications (hormones) to help your body to change?
5. What medications are you using?
6. From where do you get these medications?
7. When did you start to take these medications?
8. Have you had surgery yet? (Top or Bottom Surgery)
9. Which surgery have you had?

Interview Questions

1. Please tell me, how has your health been since you started hormonal therapy?
2. Do you consider the changes in your health to be related to taking hormone therapy?
How so?
3. What have you done about these health problems?

4. How did you learn about what to expect to experience whilst taking hormone therapy?
5. Have you had the surgery yet?
6. Tell me how your health has been since the surgery?
7. How do you manage your health problems that are related to your current treatment?
8. Have you been to health service e.g. clinic or hospital for any of the hormone therapy-related problems, if so, please tell me what has been your experience during these visits?
9. How did the nurses and doctors respond when you explained your health problems and asked for help?
10. How did the responses of the doctor/nurse make you feel?

Probing questions will be asked to further understand the experience of the transsexual women.

Appendix D: Afrikaans Information Sheet (Inligtingstuk)

Ek, Douglas Newman-Valentine, studeer tans vir 'n doktorsgraad (PhD) aan die Universiteit van Kaapstad, Departement Gesondheid en Rehabilitasiewetenskap, Afdeling vir Verpleegkunde en Verloskunde. Ek doen navorsing ten einde te verstaan hoe bewus transseksuele vroue is van hul unieke gesondheidsbehoefte en hoe hulle te werk gaan om gesondheidsorg te soek vir probleme rakende hul geslagsheroïentasieterapie. Hierdie tipe navorsing is nog nooit voorheen in Afrika gedoen nie. U deelname sal ander transseksuele vroue help om hul gesondheidsbehoefte te identifiseer en toepaslike gesondheidsorg te vind.

Wat word van u as deelnemer aan die studie verwag?

Indien u instem om aan die studie deel te neem sal ek een keer met u ontmoet vir 'n onderhoud wat ongeveer 90 minute lank sal duur. Ons sal die onderhoud doen waar ook al u die gemaklikste voel, en op 'n tyd wat vir u geskik is. Ek sal u vrae vra oor u gesondheid en u ondervindinge van besoeke aan 'n kliniek of hospitaal toe u gesondheidsprobleme ervaar het.

Ek wil u vra of ek ons onderhoud kan opneem en ek sal notas maak terwyl u met my gesels. Die opnames en notas sal my help om alles te onthou wat u aan my vertel het. Daar is geen regte of verkeerde antwoorde op die vrae wat ek gaan stel nie, en indien u nie enige van die vrae verstaan nie, moet u vry voel om onsekerhede met my uit te klaar. Indien u voel dat enige van die vrae wat ek stel te persoonlik is, mag u verkies om daardie spesifieke vraag nie te beantwoord nie. Indien u ongemaklik voel met die klankopname, sal ek nie die onderhoud opneem nie, maar sal slegs notas maak.

Wat is die potensiële voordele?

Daar is geen direkte voordeel in U deelname in hierdie studie nie, maar U deelname aan hierdie studie sal u 'n geleentheid bied om u lewensondervinding met my te deel, en ek sal poog om positiewe verandering te bring in die lewe van mense wat soortgelyke veranderinge as u deurmaak. Die inligting wat u deel, sal my help om hierdie studie te voltooi, en die resultate sal moontlik tot voordeel wees vir ander transseksuele vroue wat tans geslagsheroïentasieterapie ondergaan.

Wat is die potensiële risiko's?

Daar is geen verwagte risiko's nie. Maar daar is 'n klein kans dat u moontlik angstig sal voel tydens die onderhoud. As u angstig voel in enige stadium van die onderhoud, stel my onmiddellik in kennis. Ons kan gesels oor u angstigheid en die onderhoud uitstel totdat u voel u is reg om voort te gaan. Indien die angstigheid voortduur, sal ek u na 'n berader verwys. Berading sal verskaf word deur opgeleide beraders wat verbonde is aan Gender Dynamix, 'n NGO wat transseksuele vroue ondersteun. Indien u die berading staak, sal daar geen negatiewe gevolge wees nie.

Vertroulikheid

Die inligting wat u in ons onderhoud deel, sal met vertroulikheid hanteer word. U regte naam sal nooit in die analise van die data gebruik word nie, en niemand sal u ooit met die navorsing kan verbind nie.

Vrywillige deelname

Deelname aan die studie is vrywillig en deelnemers kan te eniger tyd uit die studie onttrek tydens die onderhoud sonder om benadeel te word.

Waar kan ek meer inligting oor die studie vind?

Indien u enigsins meer inligting oor die studie benodig, voel vry om die volgende persone te kontak:

1. Mede-professor Sinegugu Duma

Navorsingleier

Tel: 021 650 6428

E-pos: Sinegugu.duma@uct.ac.za

2. Professor Marc Blockman

Voorsitter van die Fakulteit Gesondheidswetenskappe Menslike Navorsingsetiek komitee

Tel: 021 406 6496

E-pos: marc.blockman@uct.ac.za

Wat doen u indien u aan die studie wil deelneem?

Indien u instem om aan hierdie studie deel te neem, sal u 'n toestemmingsvorm moet onderteken as bewys dat u verstaan waarom die studie gaan en dat u vrywillig deelneem.

Dankie

Douglas Newman-Valentine

Navorser

Tel: 021 650 6619

E-pos: douglas.newman-valentine@uct.ac.za

Appendix E: Afrikaans Informed Consent Document (Ingeligte Toestemmingsdokument)

Toestemming om Deelname aan die Studie:

Ek (Naam en Van) het die inligting geles rakende hierdie studie aangeheg aan hierdie dokument en het alle onsekerhede met die navorser uitgeklaar. Ek verstaan die doel van hierdie studie en my betrokkenheid as deelnemer.

Deur die toestemmingsvorm te teken stem ek vrywillig in om aan hierdie studie deel te neem.

My rol sal wees:

1. Om al die vrae wat die navorser tydens die onderhoudssessie aan my stel te beantwoord.
2. Om die navorsing te vra om iets wat ek nie verstaan nie, aan my te verduidelik.

Risiko's

Omdat ek persoonlike inligting met die navorser sal deel, verstaan ek dat ek dalk angstig mag voel. Indien dit gebeur, sal ek onmiddellik die navorser inlig. Ek sal saam met die navorser my angste aanspreek en die nodige aksies neem soos in die inligtingstuk verduidelik word.

Vertroulikheid

Die navorser sal alle inligting wat ek met hom deel as vertroulik beskou. My regte naam sal nooit in enige verslae of publikasies wat uit die hierdie navorsingstudie voorspruit, genoem word nie.

Voordele

My deelname aan hierdie studie sal my 'n geleentheid bied om my lewensondervinding met die navorser te deel, en die navorser sal poog om positiewe verandering te bring in die lewe van mense wat soortgelyke verandering as ek deurmaak. Die inligting wat ek deel, sal die navorser help om hierdie studie te voltooi, en die resultate sal moontlik tot voordeel wees vir ander transseksuele vroue wat tans geslagsherooriëntasie-terapie ondergaan.

Vrywillige deelname

Deelname aan die studie is vrywillig en **ek** kan te eniger tyd uit die studie onttrek tydens die onderhoud sonder om benadeel te word.

Deelnemer

Datum:

Navorser

Plek:

Appendix F: Afrikaans Interview Schedule (Afrikaanse Onderhoudskedule)

Onderhoudskedule: indiepte-onderhoude

Opdrag

U is gekies om deel te neem aan hierdie studie omdat u ondervindings my kan help om belangrike kwessies te verstaan wat u gesondheidsbehoefte en die gesondheidsdienste wat u ontvang as 'n transseksuele vrou tydens u seksuele heroriënteringsproses beïnvloed. Die onderhoud sal omtrent 90 minute duur. Ek sal u 'n paar vrae vra. Daar is geen regte of verkeerde antwoorde op die vrae wat ek gaan stel nie. Voel vry om die vrae na die beste van u kennis te beantwoord, en vra my asseblief indien enigiets onduidelik is. U antwoorde sal nooit aan u naam verbind word nie.

Agtergrondvrae:

1. Naam:
2. Ouderdom:
4. Hoogste vlak van opvoeding:
5. Gebruik u enige medikasie (hormone) om u liggaam te help verander?
6. Watter medikasie gebruik u?
7. Vanwaar kry u hierdie medikasie?
8. Wanneer het u begin om hierdie medikasie te gebruik?
9. Het u al chirurgie (Bors rekonstruksie, orgidektomie, vaginoplastie) ondergaan?
10. Watter tipe chirurgie het u ondergaan?

Onderhoudsvrae:

1. Vertel my asseblief hoe u gesondheidstoestand is sedert u hormonale behandeling begin het.

2. Skryf u die veranderinge in u gesondheid daaraan toe dat dit verband hou met die hormoonbehandeling? In watter opsig?
3. Wat het u gedoen omtrent hierdie gesondheidsprobleme?
4. Hoe het u geweet watter ervarings om te verwag terwyl u die hormoonbehandeling ondergaan?
5. Het u al chirurgie ondergaan?
6. Vertel my hoe u gesondheid is sedert die chirurgie.
7. Hoe hanteer u u gesondheidsprobleme wat verband hou met u huidige behandeling?
8. Was u al by 'n gesondheidsorgdiens, byvoorbeeld 'n kliniek of hospitaal, vir enige van u hormoonbehandelingsprobleme. Vertel my meer van jou ondervinding tydens die besoek.
9. Hoe het die verpleegsters en doktors gereageer toe u hulle om hulp/sorg vra vir u gesondheidsprobleme?
10. Hoe het die reaksie van die doktors/verpleegsters u laat voel?

Bykomende noulettende vrae sal gevra word om verder die ondervinding van transseksuele vrou te verstaan.

Appendix G: Transcribed Interview (Participant 3)

Interview 3

Participant: Caroline

Date: 3 September 2013

Place: Mowbray

D: Ok, Good morning Caroline, Thank you for signing consent and being willing to participate in my study. I have a couple of questions that I will be asking you. Feel free to answer them. Caroline, I am going to ask your name again.

C: Caroline

D: And your surname

C: [Removed to ensure anonymity]

D: Your age

C: 30

D: Your highest level of Education

C: Grade 12

D: Tell me Caroline, are you using any medications or hormones to help you change your body?

C: Yes I am on Estrofem.

D: Hmm, and the dosage?

C: I am currently now on 2 mg.

D: OK, that is 2 mg in the mornings?

C: Yes, just one tablet.

D: OK.

C: And, it keeps on changing because they have discovered that I have got a fatty liver, so whenever they see that the liver levels goes up the dosage comes down.

D: It's only the Estrofem?

C: Yes.

D: You are not using Androcur?

C: No blockers due to the fatty liver.

D: From where do you get these meds?

C: From Hospital X.

D: And when did you start to take the Estrofem?

C: I started exactly a year and three months ago.

D: So that would be?

C: June last year.

D: June 2012.

C: Yes.

D: Have you had any surgery yet?

C: No.

D: Thank you. So Caroline, can you tell me how has your health been since you have started the hormone therapy?

C: That's a bit... ok, let me see, since I have started the hormone therapy I have discovered things that I didn't know like the fatty liver. I would not have known about it if I did not come for the treatment.

D: OKk, did you have that before the hormones already?

C: No, upon coming to Hospital X, they do some blood tests and that was when they discovered that I have a fatty liver.

D: Was that after you have started taking the hormones?

C: No, yes, but it was on the same journey, and that is the reason why I only started a year and three months ago because they had to be certain that the liver won't be affected dramatically.

D: OK.

C: And, ja, I think that is the only health issues, but it is not actually a problem at the moment because I don't get medication for it, so it is just a caution.

D: Hmm.

C: That they are taking.

D: But were there any changes in your health? Your general health? Has it changed since you started this journey?

C: (Pause) Not really, a few stuff has changed like the fact that I get tired very easily, I'm not as active as I used to be. Just a small walk up here (laughter) was "uitputtend", and ja basically the hot flushes. OOOh that is terrible, I dread the summer coming on (laughter), and ja that is basically it. That is the only health issues I have.

D: Hmm: tell me.

C: A few skin problems.

D: OK, and if we look at the tiredness that you are experiencing, can you tell me about that?

C: That tiredness is extremely exhausting. I used to, I used to be a very active person. I could start weekends ... it's from Friday to Sunday supposedly, but mine started Wednesday (Laughter). But I can't do that anymore. I find myself being extremely tired. Especially during the week, and nowadays I don't even do that much on weekends anymore, but the little that I do, It feels like I did, you know, a few months' work. And like even, I'm not even into clubbing anymore that much. I used to be mad about the dance floor, just to jazz. I can't even spend 20 seconds on the floor and then I am so tired. It's really... That's the only issue I actually have.

D: And does the tiredness influence your work performance?

C: Yes, it's like now I will do two or three clients and then I have to take a break. You know, whereas before I would have started to work at 9 and work straight through until lunch time and then take a break unless there is no clients, but I can't do that anymore. And I have to go to the loo just to go wash my face cause I am sweating continuously.

D: Which brings me to the hot flushes. It is constant, tell me about the hot flushes.

C: It happens mostly at night.

D: OK.

C: But in the summer it's a whole different story. It is basically almost the entire day. And the other thing is ... it's like it basically just added cause before I started the hormones I used to sweat very easily, and now it is just worsened.

D: OK, there is a definite increase.

C: Yes.

D: You told me about skin problems?

C: I have discovered that I have got dry skin now, and it kind of looks like eczema and it is something I have never had. It started after a few months. Round about 7, 8 months on the treatment I started discovering that, and that is still something that I must bring up with my doctor. But I never get a chance because I see a different doctor all the time. And you sometimes come to the hospital, you are prepared, you know what you are going to say. There are certain issues that have occurred along the way and you have decided that this is what I want to discuss, but then you get another different doctor.

D: OK.

C: And then he wants to take you down the whole journey again from day 1. And I mean honestly, I have been on the treatment so long now already. Sometimes I feel like recording myself and playing it for them. Because it is like you are singing the same song. Doesn't matter which department you go to, it's the same story. By the time they are done and ask if there is something that you would like to ask ... it's like you have forgotten about it and you just want to go because the pharmacy is closing. It's already an afternoon clinic; otherwise you will have to travel back the next day just for medication.

D: And how does it feel, I hear some, I hear you saying that you need to tell the whole story again. What about that? How does that make you feel?

C: To be honest, I don't mean to be rude, but I am pissed already. Its ... I mean I sometimes feel like, it feels like a big joke to me. Or I actually think they think it's a big joke to explain the same story over and over and over. I mean why they are taking notes when you are in there? Can't you just go through my file? Everything is supposed to be there; if they do their jobs correctly it will be there. So why not just go through the file and see what previous doctors wrote and take it from there? Why feel the need for me to explain the whole story again?

D: Why do you think they ask you the whole story every time?

C: What I have discovered at the endocrine clinic is, I think most of the time it is ... Some of them find it humorous, because the look on their faces ..., some of them don't want to do their jobs because you get the one doctor this month that actually tells you to take off your clothes to see the progress and whatever, and three months down the line you get a doctor that just sits there and listen to your story and write crap, and don't even ask about the changes and progress. So I think sometimes I think it's due to laziness. And not all of them is the same, and I think it would be much better if you only had one doctor that knows you and you know them cause I think this is a very, it's extremely personal

and private. And I might as well see my doctor, you know out in the hall or whatever, the hallway or at reception. I can sit in front of everybody cause it's like I am telling my story to the whole of Hospital X. I have seen how many doctors and how many nurses I have been through, so I might as well tell the whole Hospital X. That is how I feel.

D: Sjöe Caroline.

C: Laughter.

D: Coming back to, and we will give some more time to speak about that because I can hear some concern from your side. Taking you back to the health problems that you have. Do you think they are related to your hormone therapy?

C: Most definitely, because at the age of 30 that is stuff that should have come out long before now I mean. Like the changes and stuff, I know that is due to the treatment, and but I mean I have been doing the same stuff year in and year out. The only thing that I did differently was to start the hormonal treatment, so that could be my only conclusion.

D: OK, Caroline, and what have you done about these health problems?

C: Well, I am only seeing the doctor now in September, so I plan on writing everything down because I am tired now of coming to Hospital X with your problems and then going home without even having had the time to tell the doctor that this is what I have been experiencing and stuff. Because if it is not the long wait that you sit in there cause they feel the need to help other patients first. OK, I don't have a problem with wheelchair patients, I understand that. I don't have an issue with that cause there is never more than 2-3 wheelchair patients. Patients from outside Cape Town I also understand, but they should also understand, why do they tell us to come before seven and give them the same time, but then I have to wait, because the sisters decide who goes in first. Why give me a number downstairs? You might as well let the sisters decide who goes in.

D: You don't think that's fair?

C: Not at all. I mos also have a life.

D: Tell me Caroline, where did you learn of what to expect, what's going to happen with your body, the changes and the side-effects of the treatment that you are taking? Where did you get information?

C: The majority of my information came from friends and my own research. By the time I came to Hospital X, I already knew what would happen, what was bound to happen. So, actually the doctors couldn't tell me anything I didn't know already.

D: OK, did they took time to still tell you?

C: Some did, some did not

D: OK, and what was the extent of this information that they have given you? What did they tell you?

C: OK, I think they didn't, they don't prepare you fully. I think they just ... tell you the basics that they think you need to know.

D: Such as?

C: Such as that everybody's bodies are not the same. I mean that we all know. I mean honestly. And ja just about the bodies that ain't the same so the treatment won't work the same. And certain changes on your body. That's it. Actually that is what I got. I can't speak for the others.

D: We are just speaking about your experience.

C: And like I feel like the hot flushes, the skin changes, the depression, that is stuff they didn't prepare me for.

D: OK.

C: Which I felt was actually part of their job description to prepare me for stuff like that.

D: Ya.

C: And maybe give you a lifeline along the way. If this and that should occur and you feel the need. You know!

D: Yes, can you tell me. You didn't mention the depression earlier, but it came up now. Do you suffer depression?

C: Not anymore.

D: OK.

C: I used to, I even took some tablets, landed up in hospital.

D: OK.

C: And, ja.

D: OK, and when did that happen?

C: That happened round about ... What I was told by friends that the depression story will only happen for the first three months. Which it didn't, mine started the 4th and 5th month and in the 6th month, and by the time it got me I was at an all-time low at that moment ... Ja, just happened at the wrong time..

D: OK, I understand. Tell me, you said you didn't have surgery yet. DO you plan on having surgery done?

C: At this moment in time right now, I'm not so sure anymore.

D: OK.

C: I'm honestly not sure anymore. And, I'm quite certain about the breasts. Actually when I started the journey I was sure 100% that I want the full sex change, and right now, I'm not so sure anymore. I can't even tell you why, cause I know that is bound to happen. You were going to ask me why (laughter), but honestly, I honestly can't tell you why. It's just, I'm not saying I don't want it anymore, I'm not saying I want it. I am just torn at this moment. I'm just at a place in my life now that I have got bigger things to worry about and it's not as if I am putting my life or myself on hold because That part of my journey aint happening soon anyhow. Because there is a whole procedure and there is a waiting list and the ... and I think part of my decision is the whole..sorry.. Fuck up with endocrine, cause I mean. Right enough I started the treatment a year and three months ago, but I have been here almost three years. And, OK my liver problem was part of the prolonging, and , but I think due to the fact that I every time see different doctors, I was supposed to be at plastics two, three times already. They have sent me there once only and they sent me there even before they started my treatment. And when I got there it was a waste of my taxi fair and a waste of my whole day. Cause I sat there the whole day, was helped at half past three only since the morning and when I got there the doctor told me "Did you start your treatment yet?" I said no, he said OK come back when you start your treatment. So why send me there in the first place? I am on the treatment now a year and three months. I have not yet been sent to plastics. People that started treatment two weeks has been there. So, it's really a big problem with you having to see the doctor, different doctors every month, or three months or six months, pending on your next appointment.

D: You spoke about the waiting period. What is the information that you got about the waiting period?

C: Now that is another story. I have not yet been to plastics, so I have not yet heard from a doctor that side that can tell me. The only information that I have is from my transgendered sisters and people that has been there. And that is the only information that I am getting.

D: And what is your sisters saying?

C: Some say ten years, some say 15 years, so honestly why make a decision now? I might be dead god forbid (laughter) I mean, I am already 30, imagine If I should have surgery when I am 50. Do you understand? That is why I am not certain anymore. I am not by the means to pay. I mean 50 thousand? Where do I get that kind of money? Would I be here at Hospital X if I had the money?

D: So do you think you would feel different about surgery if you were by financial means to pay and you did not have to come to this clinic?

C: Most definitely.

D: Caroline, let's speak about the health service. Have you been to a clinic or hospital for issues related to your hormone therapy or any other other issues and lets speak about your experience of those visits to hospital.

C: Well, I have had a problem with the day hospital.

D: OK.

C: That's why I am now getting my meds at Hospital A because the day hospital is around the corner from me. I have found it much easier to go there if it is just for meds. Instead of coming all the way to Mowbray, and at first it was quite fine, but then every time I went, and then they would tell me no, you should come back next week. You know when you get a prescription there is no certain date on it.

D: OK.

C: So you count 4 weeks, so in that fourth week I will go the day hospital like I normally did and it was never an issue, and they started telling me: "No it is not time to get your meds yet, you must come next week". I would ask when in next week, they said any time. That means I can come between Monday and Friday. Any which day I feel fit or feel that I have nothing going on that day I will go to the day hospital. And then I will get there and they will tell me: no sorry, you are two days too late. There is no medication. Firstly I am not a chronic patient. Only chronical meds gets sent from Hospital B to the day hospital, which is packaged and after two to three days if you don't come and fetch it, it gets sent back. I am on hormonal treatment and it is at the day hospital and it gets sent nowhere. So how come I cannot get my meds. Why must I come back, get another date from Hospital X and come back? It happened thrice. I complained, nothing happened, and so I told them here at Hospital X, either you give my meds here or I will make a big issue out of it.

D: So was it the pharmacists or who told you you must come back every time at the day hospital?

C: It happened at the reception!

D: Was it the clerk?

C: Yes, "Is mos nou vir hulle fun om vir jou vir n gat te vat, om so te se."

D: OK, so you do think it personal.

C: Yes, most definitely.

D: Have you ever been admitted to a hospital, other than coming here to Hospital X?

C: Yes, quite a few times.

D: Let's talk about that.

C: Hmm, the majority of the times it was before my treatment, and ... that times I didn't see anything wrong with the treatment I got. I understood, you know, that moment in time they just see you as a gay person although you don't identify as one. But (sigh), and that times you are not up... for that type of confrontation. You in that hospital for a reason, and but the time I did feel (laughter) to be bitchy. Something happened after I started my hormone treatment, and after I have seen changes on my body and stuff like that and, having have identified as a woman most of my life, I felt more like one in that moment in time cause there is certain stuff that I could see. Physical changes.

D: Yes.

C: That in the eyes of so-called straight people makes you female or feminine, because if you have breasts you know, you are female. And like the day I took the tablets.

D: Yes?

C: And I was rushed to Elsiesriver day hospital ... Went in there, and then ... one of the sisters came over, and hmm, took blood and all that crap. Told me to, uhh, take my clothes off. I took my clothes off and she came in there and just said Ohhhhhh, and just went out again. She came in with two more sisters. And I was like, OK, it was now OK for you to be alone here to do whatever you needed to do, so what is this now? And I knew it was for the fact that they could see breasts ... and the bottom part was not what is was supposed to be in their eyes. And I felt embarrassed.

D: HMM.

C: And, OK, I sat there. I was heavily depressed, and the stuff I took was an indication that my depression was at an all-time low. And for her to be so stupid to still do that shit? Hmm, actually made me wish that ... I actually died that moment when I took the tablets. And that was that. (Silence)

Caroline breaks down and cries

D: And that was what happened. You can take your time. Do you want to take a breather? We can stop for a while.

C: Just for a few seconds please.

The interview was stopped for 20 minutes. We reflected on Caroline's distress. I offered her water, tissues and a biscuit. She calmed down and said that we can continue with the interview. She said that even though it hurts to tell her story, she hopes that it will make it better for other women in her situation.

D: Hmm, So Caroline, thank you for allowing me to continue with this interview. We were speaking of a time when you were at a very low point in your life and you didn't feel that you got caring treatment from health personnel and that added to your distress at the time. Is there anything more about the time that you can tell me, and what you experienced in the hospital? Did you stay in Elsiesriver or were you transferred?

C: I was actually transferred to TBH from there. Where I had to sit an entire night in the chair.

D: OK.

C: With a lot of other patients who were sleeping on the floor, and when they finally decided to put me in a so-called ward, I had another issue where they wanted to put me with male patients.

D: OK.

C: And I clearly felt that they were discriminating.

D: Hmm.

C: Which, and I mean if they did not know I would have understood, but firstly, while sitting there, they thought I was a female.

D: OK.

C: And just because the name change was not finalised yet, they called me on my male name.

D: OK.

C: And I had to respond to it, and just because of the name they decided that I should go into a male ward. And I refused to. I told them if that is what you guys want to do, then I suggest you guys discharge me now and I will sort my own problems out at home. Because I am not going into a male ward, and if you don't want to put me in a female ward, then put me somewhere where I am alone. And I had issues that whole day. And they left me at reception until a doctor could come there and he took me to a room where we could be alone, and did what he had to do, and then from there I had to go back to the waiting room and sit there until I could see a psychiatrist, because there is no wards for trans women.

D: Sjoie, OK, and was this the nurses that made that decision?

C: Yes.

D: OK., And is there other things that maybe the nurses or the doctors said to you that you want to talk about?

C: Actually I never had a problem with doctors at TBH, I have been there before, cause I had a stomach problem. Nurses, I have never had a problem, but that was the first time. And they will come in and then they pick up the folder and then they will look at you and call their colleagues and it is now a big joke.

D: Hmm.

C: The Africans, they will talk in their own language and you know, facial expressions says a lot. Even body language. And I mos now know the joke is on me! And, most of the time I am very outspoken, and I don't care if I am going to offend you, cause you didn't give it a second thought when you offended you. Like they say payback is a bitch, but I'm not even trying to pay you back. I just want to defend myself. But I don't see the need to defend myself when I come to a health clinic. Especially when it is a government clinic. Then why are you working there in the first place?

D: Hmm.

C: If you don't know how to work with people or treat people. Then get yourself a job where you are isolated.

D: Indeed, I know you have spoken about it, but how does these reactions and I am thinking about what you said earlier, that you will get dates and be send around, and don't want to give you meds, and the way you were treated at TBH and Elsies. How does these reactions make you feel?

C: I'm actually angry! I feel that somehow, I am getting the short end of the stick just because I am trans. Or just because I am not so-called normal to what people think normal should be. Because I mean honestly, when did you decide what should be normal and what's not normal? I mean if I had a choice, this is most definitely not a road that I would have picked for myself. Because who in their right minds would put themselves on this emotional roller-coaster, and have people try to belittle you, in front of other people? You already get stares from other patients and stuff. OK that is normal,

I am used to that now really. Most of the time they don't even know until one of the sisters calls out the name, And they see you how many times, they know the situation. They have been told by doctors, your female name is written on there. Why don't you just call the surname, but they feel the need, some of them feel the need to belittle you, and I mean it is so childish. At first it was hurtful, but not anymore. My skin have grown so thick, and I didn't need hormones for that (laughter). But, ja, I don't although think I've got the shorter end of the stick, I still that I have a lot going for me. And that is what actually keep me going. Makes me want to get up the following morning and you know. Just see the look on people's faces. I don't care if it is at clinics, day hospitals, private hospitals. I don't care. Just the look on their faces, when they see you walking there. You can make fun, I don't care. That last for 2-5 seconds. Not even 5 minutes.

D: But it's different when you get that from healthcare professionals.

C: Which is supposed to be professionals. Professional being the key word there. Now where is that professionalism that moment in time when you get a trans woman or a transgendered male? Whether it is a normal gay person, I call it normal gay, but for them it is not normal.

D: Sjoie, Hmm, Caroline, Have you ever experienced violence that you think is related to you being trans?

C: No, not at all. Not yet (laughter).

D: So you anticipate violence?

C: (Laughter) I'd rather say not yet. You know it is common, I have actually taught myself not to get in, or to be, to lower myself to their standards. I mean because that type of confrontations is bound to lead to something more. And my boyfriend, nobody especially if it is males, like you know you will walk in the road or go out shopping wherever, that's why I only brought him last week with me to Hospital X for the first time. Because people always say stuff, and I don't take note of it anymore, but it offends him because he feels that it is hurting me.

D: He is protecting you.

C: Yes, that is one of the reasons why I don't take him certain places.

D: And it seems like you are in a stable, happy relationship.

C: I sure am!

D: OK. That's good to hear. Caroline, what do you think can be done to make health care better for transsexual women?

C: I think if they could maybe implement some workshops and stuff, for the staff at the hospitals. I mean. OK, they go to colleges, nursing colleges and stuff, but, they only... It's like their education they go there, they get taught certain stuff, but I mean, to them going there it's like, in their minds they will be working with straight people. They wanna tell you that everybody's body is not the same, it reacts differently. I mean by them telling you that they should bear in mind that each and every person is an individual in their own right and whether I choose to live a different life. I mean that is supposed to be, that is my right as a human being. And, OK, this was my choice to go on the hormone treatment, that was not forced upon me, that was my choice. But I didn't wake up one morning and decided I want to be trans, or I discovered I am trans. You know. I was born a male ... due to the fact that I have got a penis. That's why there was written male on my Birth Certificate. If there was a vagina they would have written female. You catch my drift, I mean, certain aspects that define who you are supposed to be.

D: And that is not who you are.

C: Exactly!

C: And I think it is much worse to live a lie. I would rather deal with stupid people, than living a lie. That is way too much to bear. (Caroline becomes teary)

But I think workshops and while they are at college. Tell them, inform them about trans people, you know. Certain stuff. Certain people that you have to deal with. I don't know why I should say certain people. It's like we are some type of nation of our own (laughter). It's like we are from Mars.

D: Aliens?

C: Yes!

D: I get that. Caroline is there anything else that you think you need to tell me?

C: I have been talking the whole time know (laughing). Can't even remember.

D: Let me recap.....

C: Nothing that I can think of. I think that my main objectives at this moment is I think if staff were better equipped to deal with trans patients. I think this whole journey would be much easier and I mean, why should you still feel the need to deal with, how can I say, with their crap. If you already get it from the outside and I mean, when coming here, they are the professionals. They already know what is going to happen to your body. Certain changes and stuff like that. So call you into a room and tell you this and that. But it is like they see a trans person for the first time, every single month when you come here. It's like Guy Fawkes (laughter).

D: Caroline, and do you think trans women have enough information?

C: No, I clearly don't. Like, just for the fact that last night I slept by my friend who is actually here today. And she is now almost three months on treatment. And most of her information she got from me. And whereas I got it from somebody else. But it didn't come from the professionals... and

D: You don't know if it is the truth?

C: You Know (chuckle). But in her case she knows how long I have been on treatment. She has been with me through the journey and she knows what to expect. Certain things are happening to her that did not happen to me and she does not know how to deal with it. You know, like an example of last night. We were 4 girls sleeping over at her place, and I was actually in the loo, and I heard the other two calling my name and I came out, and she was laying on the bed crying continuously and she couldn't stop. And she looked up and burst out in tears again and you know. And we all assumed that it was due to the medication. I mean she was not prepared for that. She was not told that it would happen. They only tell you there is two side-effects and it is weight gain and certain mood swings, but I mean moods swings could mean anything. Why not be more clearer upon when you say certain stuff and define it. When you say mood swings, it's this and that and that, you know? Then I know what to expect. Now we had to assume and say this and say that and then she cried, then she'd laugh. And you don't know if you are saying or doing the right thing, but ja, I told her to talk to them about it today.

D: Ok Caroline, I think that we can conclude. If you feel you have anything more to add, you have my contact details

C: One more thing.

D: I'm listening.

C: Why isn't there like a personal link between the hospital and Home Affairs.

D: OK.

C: with the name change thingy. You go there, you go through a whole procedure. They want the letters and stuff from the doctor. You give it and stuff. You come here they say no they can't change your name until the documents is there in front of them, that it is not Caroline and this and that. And I mean why still go through this whole transformation. Half of your body is changed into totally being female, and then you come still here waiting for the ID how long now, over 6 months, and there is always an issue. Come here then you still get degraded cause now you must be back on the male ... the born name, the one given by your parents. Walking in here with big breasts and being called that name, I mean, it is humiliating. Standing up in front of everybody, so why can't they have a personal link, that will be so much easier and less embarrassing.

D: What I hear is that from the hospital side, they should also assist trans women from one government department to the next.

C: Yes.

D: When you start the treatment, you are changing, you are women and you need to get your ID sorted because you have now changed to a woman, but you must still deal with an ID that is male.

C: Exactly.

D: I get that. OK, thank you Caroline.

C: It's a pleasure.

Appendix H: Peer-reviewed publications

Whilst undertaking this study, I have published two articles in peer-reviewed academic journals based on this study. The first article is a review article based on the literature review conducted in this research. The second article disseminates selected findings revealed in this research. (See below.)

Injustice to transsexual women in a hetero-normative healthcare system

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Background: Transsexual women who are on the journey of sexual re-alignment will experience various health problems. These problems are related directly to the treatment regime that they are following in order to attain and maintain their physical embodiment as a woman. They are forced to negotiate a hetero-normative healthcare system in order to receive assistance and care for their health problems related to their sexual re-alignment process.

Aim: The questions posed were: What are the unique health problems that transsexual women experience whilst on the journey of sexual re-alignment? What is the current context of the South African healthcare system in which transsexual women should negotiate healthcare? These questions were asked in order to explore the health problems with which transsexual women are faced and to describe the hetero-normative healthcare system in South Africa.

Method: An electronic literature search was executed via the EBSCO host with specific inclusion and exclusion criteria. The search words that were used were: Transsexual/s and Health/Healthcare. All studies had to be peer reviewed and published in the English language, from January 1972 up until February 2013. Literature on transsexual children was excluded.

Results: Transsexual women have the potential to suffer significant side-effects from their sexual-re-alignment treatment, including cardio-vascular problems, endocrine problems and mental ill-health. They are also vulnerable to HIV infection. They have poor access to quality holistic healthcare and this may lead to an increase in the mortality and morbidity figures of women.

Conclusion: A hetero-normative healthcare system has a negative impact on the health of transsexual women and will cause them to be marginalised. This could contribute to both homo- and trans-phobia that will in turn strengthen the belief that transsexual women are un-African.

Injustice envers les femmes transsexuelles dans un système de santé aux normes hétérosexuelles.

Contexte: Les femmes transsexuelles qui sont sur le chemin du réalignement sexuel souffriront de différents problèmes de santé. Ces problèmes proviennent directement du traitement qu'elles suivent pour atteindre et maintenir leur corps de femme. Elles doivent surmonter un système de santé aux normes hétérosexuelles pour recevoir de l'aide et des soins pour leurs problèmes de santé liés au processus de réalignement sexuel.

Objectif: Les questions posées étaient: Quels sont les problèmes de santé particuliers que les femmes transsexuelles rencontrent sur le chemin du réalignement sexuel? Quel est le contexte actuel du système de santé sud-africain avec lequel les femmes transsexuelles doivent négocier leurs soins? On a posé ces questions pour examiner les problèmes de santé auxquels les femmes transsexuelles sont confrontées et décrire le système de santé hétéro-normatif en Afrique du Sud.

Méthode: On a effectué une recherche de littérature électronique par l'hôte EBSCO avec des critères spécifiques d'inclusion et d'exclusion. Les mots de recherche utilisés sont: Transsexuel/s et Santé/Services de santé. Toutes les études ont été vérifiées par les pairs et publiées en anglais, de janvier 1972 à février 2013. On a exclu la littérature sur les enfants transsexuels.

Résultats: Les femmes transsexuelles peuvent ressentir des effets secondaires significatifs de leur traitement de réalignement sexuel, tels que des problèmes cardio-vasculaires, endocrines et de santé mentale. Elles sont aussi vulnérables à l'infection par le VIH. Elles n'ont pas accès à des soins de santé de qualité ce qui peut augmenter les chiffres de mortalité et de morbidité des femmes.

Conclusion: Un système de santé hétéro-normatif a un impact négatif sur la santé des femmes transsexuelles et les amènera à être marginalisées. Cela pourra contribuer à l'homo- et trans-phobie qui à leur tour renforceront la croyance que les femmes transsexuelles sont contraires à la mentalité africaine.

Introduction

Transsexual women experience significant health problems which are related directly to their gender re-alignment journey. They have to negotiate care in a hetero-normative healthcare system, which is exclusive.

The reviewed literature in this article explores the health problems which transsexual women experience and makes a description of the hetero-normative health care system in South Africa, after which appropriate recommendations for practice and research are made.

Transsexual woman: A definition

The term Transsexual describes someone who identifies psychologically and emotionally as having a gender identity in opposition to that which was assigned at birth. Someone who identifies as transsexual or transgender may want to make changes to their body using hormones or gender confirming surgeries to transition their physical features to match their internal sense of gender.¹

A transsexual individual can further be described as a person who wishes to be of the opposite sex and is in the process of gender re-alignment.²

A transsexual woman is a person who was sexually defined and registered as male at birth, but identifies psychologically as female. She will seek medical help to align her physical embodiment with her gender and will be placed on a regime of lifelong hormonal therapy and various gender-confirming surgeries.

Hetero-normativity explained

Hetero-normativity can be described as the belief that heterosexuality is the ideal and that all other sexualities are inferior. Legal and social structures are thus designed to accommodate heterosexuality, thus denying rights and status to different sexualities.³

The phenomenon of hetero-normativity is evident in all sectors of daily life. In most of the African countries, marriage is only recognised between a man and a woman. This immediately gives a superior status to the heterosexual union. At government institutions, banks, schools and universities, one of the first categories in which people are placed is either male or female. Even in culture, hetero-normativity is so deeply ingrained that it is often missed. When a child is born, the first information that a midwife or doctor will give a mother is the sex of the child. Family will usually enquire about the sex of a child before they question the health and well-being of the mother and the baby. This will be followed by 'gender appropriate' gifts and toys, as people naturally see gender and sex as being interchangeable.

Methods

The literature review was done in a systematic manner. The search

The search words that were used were: Transsexual/s and Health/Healthcare. All studies had to be peer reviewed and published in the English language, anywhere from January 1972 up until February 2013.

All studies that were published in the Cinhal, Health Source, Humanities International Complete, Medline, Psyc Articles and Soc Index databases and which were found to be relevant to transsexuals and healthcare were included in the study. All studies that were specific to transsexual children under the age of 18 were automatically excluded.

The initial search yielded 172 studies. A total of 105 of the studies were excluded because of both the inclusion and exclusion criteria and repetition of studies on the databases. This exclusion process yielded 67 studies that were selected for the critical appraisal process.

A CASP (Critical Appraisal Skills Programme) critical appraisal tool was utilised to measure the quality of the 67 studies that were selected.⁴ After this process, another 37 studies were excluded because of insufficient rigour or reliability, leaving 23 studies which were finally selected for review.

Appropriate grey literature, such as acts and policies, was also included in this article.

Review findings

The South African healthcare system in context

Chapter two of the *Constitution of the Republic of South Africa* proclaims that healthcare is a human right for all citizens. It states that each citizen has a right to healthcare services, including reproductive healthcare.⁵ Furthermore, the *National Health Act* 2004 aims to provide the best possible health services to citizens. It is written that it protects and promotes the rights of vulnerable groups, including women, children, older persons and the disabled.⁶

Both the *Constitution* and the *National Health Act* are specific regarding who exactly would be defined as a vulnerable group, however, transsexual women are not specified. The National Department of Health has initiated and implemented various strategies in order to improve the health status of the South African population, but all of these initiatives are silent with regard to transsexual women.

The latest reform in the South African healthcare system is the National Health Insurance (NHI). The main objectives for the implementation of the NHI in South Africa are to bring reform, improve service and to promote equity and efficiency in the healthcare system.⁷ Throughout this document, the issue of equity is discussed in detail, yet transsexual women seem to be excluded in this latest plan of the South African government.

for the literature was done electronically via the EBSCO host with

specific inclusion and exclusion criteria.

In the South African healthcare system, a person is treated as either male or female and there are various health programmes that place the focus of care on either men or women, such as

<http://www.phcfm.org/>  [doi:10.4102/phcfm.v6i1.574](https://doi.org/10.4102/phcfm.v6i1.574)

the women's health and men's health programmes. This rigid form of gender identification within the health system will place people into two distinct boxes of care, with no space for people who are identified as different. With the definition of hetero-normativity in mind, where heterosexuality is seen as the norm, the South African healthcare system in effect treats people strictly as heterosexual men and/or women.

Hetero-normativity is a form of discrimination that is present in the healthcare system of South Africa, but it is not accepted as such. This leads to an exclusive healthcare system which denies a subset of the population, such as transsexual women, access to quality appropriate healthcare.

The silence with regard to the protection of sexual minority groups in the healthcare system might result in an increase in the morbidity and mortality figures of the country and is in direct conflict with the aims and objectives of the health legislation of South Africa.

Health problems of transsexual women

Literature shows that the life-long administration of feminising hormones used by transsexual women has the potential to lead to an increase in both systolic and diastolic blood pressure. Furthermore, it can increase insulin resistance in transsexual women.⁸ Pulmonary embolism, deep venous thrombosis and osteoporosis may also occur.⁹ Transsexual women require chronic management to treat conditions such as diabetes and hypertension. What makes these chronic conditions unique to transsexual women, is that they are subjected to a regimen of lifelong hormonal treatment in order to facilitate and maintain their transitioning and sexual re-alignment.

The chronic infection, HIV, may also affect transsexual women. Two large studies, conducted in the United States of America (USA), identified that 40% of the participants reported inconsistent condom use. Less than half of the respondents made use of protection during their last sexual encounter, whilst 64% of the respondents reported having engaged in high-risk sexual activity during the past three months.^{10,11}

Transsexual women are anatomically more vulnerable to HIV because of the vulnerability of the tissue in the neo-vagina and the rectal mucosa.¹¹ The immediate question asked would be why this subset of the community would take such health risks knowing that they might become infected with either HIV or other sexually-transmitted infections (STIs). It is not clear if their attending health providers inform these women about the dangers of contracting HIV and other STIs.

In 2002, Kenagy found, in a needs assessment survey, that male-to-female (MTF) transsexual women believe that they will not become infected with HIV and thus indulge in risky behaviour.¹² HIV prevention programmes in South Africa target groups other than transsexual women. It is possible that the absence of health education for this group perpetuates the belief on the part of transsexual women that they are not at risk for HIV infection.

Two USA-based qualitative studies concluded that transsexual women have a need to be accepted. They participate in high-risk sexual encounters in order to avoid rejection.¹³

Two surveys conducted in Rome and California, reported that 20% and 52%, respectively, of the transsexual women surveyed were HIV positive. It was noted that this was possibly an underestimation, since the respondents self-reported their HIV status.^{14,15}

South Africa has a female HIV prevalence rate of approximately 17.4%,¹⁶ which is high in comparison with international statistics. This elevated prevalence of HIV amongst women is a concern and could suggest an even higher infection rate amongst transsexual women because of their vulnerability.

Apart from their physical healthcare needs, transsexual women are at great risk of mental ill-health as a result of the dramatic changes they experience during their transitioning process. A USA-based survey, which looked at 446 transsexual individuals, found that transsexual women have diminished mental health as opposed to their heterosexual counterparts.¹⁷ In 2010, Hoshiai and others, identified that 72% of transsexual women had suicidal ideation, which can be correlated directly with the poor state of their mental wellness. Furthermore, androgen deprivation, which forms an integral part of the treatment toward gender re-alignment, can lead to depression.¹⁸

The prevalence of homophobia against Lesbian, Gay, Bi-Sexual, Transgendered and Intersex (LGBTI) youth is high¹⁹ and it is recognised that a higher suicide risk is present in this group.²⁰ It can be concluded that transsexual women may potentially be at higher risk for suicide because they are even more marginalised than other people of the Lesbian, Gay, Bi-Sexual (LGB) community and often suffer internalised stigma.²¹

From the above, it is clear that supporting the mental well-being of this subset of the community is challenging. It is exacerbated by homo- and trans-phobia, stigma and depression, possibly caused by androgen deprivation.

The available literature demonstrates that transsexual women are at risk of the development of hypertension, diabetes, embolism, osteoporosis, HIV and mental illness amongst others. These conditions are directly related to their journey of sexual transition and will require them to seek appropriate healthcare at all available levels of care.

Access to appropriate healthcare services

Literature from North and South America shows that access to available services for the LGBTI community remains largely limited, or that there is a complete absence of healthcare services

available to the transsexual community.^{22,23} In the USA, both African-American and uninsured, impoverished,

<http://www.phcfm.org/>  [doi:10.4102/phcfm.v6i1.574](https://doi.org/10.4102/phcfm.v6i1.574)

foreign-born transsexual women, are reported to have the least access to healthcare services.^{22,24}

Adequate access to healthcare and provision of hormone therapy significantly increase the quality of life of transsexual women. Of critical importance is the availability of trans-specific health education, which could have a positive influence on their health risk behaviour patterns.^{16,25} The knowledge of healthcare providers regarding transsexual health issues is vital for their access to and utilisation of appropriate healthcare services.

In the USA, a study of 101 MTF transsexual women found that a barrier to effective healthcare is the limited access to a healthcare provider that has adequate knowledge about the specifics of transsexual health.²⁶

Another smaller study showed that specific health programmes do not acknowledge the LGBTI community,^{19,20} but in a patient satisfaction survey of 180 transsexual women, it was confirmed that transsexual women consider their healthcare needs to be important.²⁷

Health professionals' attitude, such as respect and sensitive care, is another critical factor toward increasing access and utilisation of healthcare services by the transsexual women. This was highlighted in a study where it was found that transsexual women from Australia, America and Europe choose to have trans-related procedures performed in Thailand. The Thai healthcare system is more accepting of the needs of transsexual women.²⁸

Evidence suggests that having adequate access to trans-related healthcare is directly proportional to positive health outcomes for transsexual women. An improvement in the quality of healthcare provided to transsexual women will have a positive impact on the morbidity and mortality statistics of this group.

Transsexual women in Africa

Research in Africa is silent with regard to access to healthcare for transsexual women. It is assumed that the reason for this silence is because of the fact that any sexuality other than heterosexuality is deemed illegal in the significant majority of African countries and Africa has a very strong hetero-normative culture. It is then further assumed that African transsexual women will have poor access to quality healthcare and will contribute to the already high mortality and morbidity figures.

The population of transsexual women in South Africa is unknown. Hetero-normative census data does not make provision for documenting a transsexual woman as such. Through working with transsexual women, it has been observed that the community of transsexual women is fluid in nature. They will often move to protect their safety as they are under constant threat of transphobic

violence, including rape. The violence and rape are a result of the society's hetero-

normative belief and people will condone the violence and rape of these women because they are seen as lesser beings that can be treated in any manner.

With little known about the population of transsexual women, transsexual women indeed contribute to the mortality and morbidity figures of women. International literature clearly states that these women will experience health problems that may lead to death and chronic illness if not managed appropriately.

The difficulty arises in the reporting of mortality and morbidity figures of transsexual women, as there is no provision made in the hetero-normative reporting system for the reporting of this data. Even after death, transsexual women remain silent in the healthcare system. Without adequate reporting systems, audits are impossible and no evidence will be available to influence positive change in healthcare services for these women.

Conclusion

Literature suggests that transsexual women could potentially suffer significant chronic side-effects as a result of their treatment, such as diabetes, hypertension, osteoporosis and cancer, amongst others. These side-effects could be managed successfully should health practitioners have enough knowledge regarding trans-related healthcare. It is recommended that health practitioners be trained to manage these clients who would present at primary healthcare

clinics with their trans-related health problems. This will ensure holistic care for these women.

Transsexual women are silent in health reporting systems. It is recommended that transsexual women should be noted as such on admission to any healthcare institution and should form part of data collected in healthcare systems.

Trans-phobia is a common phenomenon. This might lead to violence in the form of physical and sexual abuse of transsexual women. These violations should be noted as 'Transphobic violence' in order to have focused treatment and to influence prevention campaigns.

Amongst various factors, the vulnerability of the neo-vagina of transsexual women and the susceptibility of the rectal mucosa will make them vulnerable to the contraction of HIV. It is recommended that health education programmes that place a focus on the prevention of HIV should include transsexual women. This could increase awareness amongst transsexual women themselves and could also inform the broader population regarding the existence of transsexual women. It is also recommended that transsexual women be included in all other health education programmes in order to reduce stigma.

Research needs to be done to describe transsexual women in Africa. Their health problems should be investigated and reported. The phenomenon of homophobic violence,

which includes rape, should also be investigated and reported as such.

These strategies will give a voice to an otherwise marginalised people, it will create awareness of the problems that a silenced community experience and it may start to break the stigma that any sexuality other than heterosexuality is un-African.

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Competing interests

The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

Authors' contributions

D.N.-V. (University of Cape Town) did this review as part of his PhD study at the University of Cape Town. S.D. (University of Cape Town) is the supervisor of this study and made significant intellectual contributions to this article.

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Transsexual women's journey towards a heteronormative health care system

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Abstract

Realigning their physical embodiment is a challenge for Transsexual women because of dependence and power imbalance they experience within the heteronormative healthcare system which is designed for heterosexual men and women's health care needs. Negotiating trans-inclusive healthcare in such a context can pose challenges for transsexual women. This study used the Interpretative Phenomenological Analysis approach to investigate transsexual women on the journey of sexual realignment in a heteronormative healthcare system in the Western Cape. In-depth interviews were conducted with ten participants who were sampled through purposive and snowball sampling. Data collection and analysis was a concurrent process after which a cross-case analysis was done. The data analysis was guided by the steps as set out for Interpretative Phenomenological Analysis (IPA). This resulted in the emergence of the main theme "*Facing the Giant in Order to Become*" which was made of the following clusters: Practitioners with power preventing progress on the realignment journey, Fearing care, and fearing transphobia. This article highlights issues affecting the health and healthcare delivery for transsexual women to assist healthcare practitioners to reflect on their automatic heteronormative healthcare practices. It also has implications for promotion of inclusivity in the development of curriculum that shapes inclusive healthcare providers. The article will hopefully serve as a vehicle to mobilise researchers to investigate issues affecting the health and healthcare delivery for transsexual women within the African context.

Keywords: Transsexual, transgender, heteronormative, interpretative phenomenological analysis.

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Introduction

The term Transsexual describes someone who identifies psychologically and emotionally as having a gender identity in opposition to that which was assigned at birth. Someone who identifies as transsexual may want to make changes to their body using hormones or gender confirming surgeries to transition their physical features to match their internal sense of gender (Spicer, 2010).

In the pursuit of gender realignment, transsexual women undergo surgery and

lifelong hormonal treatment as part of a treatment regimen. This regimen has an impact on the unique health status of transsexual women. Even though this

treatment package benefits transsexual women, it significantly increases their need to visit healthcare practitioners for management of potential side-effects.

Possible side-effects to sexual realignment treatment might manifest on a physical and/or psychological level. Feminising hormone use could result in the development of diabetes, hypertension, pulmonary embolism, deep venous thrombosis and osteoporosis (Elbers, Giltay, Teerlink, Scheffer, Asscheman, Seidell&Gooren, 2003; Persson, 2009).

The increased risk of contracting HIV infection is a reality for transsexual women, and the literature confirms that the HIV infection rate amongst transsexual women is higher than in the general population (Edwards, Fisher & Reynolds, 2007; Kenagy& Hsieh, 2005; Verster, Davoli, Camposeragna, Valeri&Perucci, 2001).

Apart from physical healthcare needs, transsexual women are at great risk of mental ill health, including depression and suicide (Newfield, Hart, Dibble & Kohler, 2006). Globally access to health services remains largely limited, or there is a complete absence of healthcare services available to the transsexual community (Harawa& Bingham, 2009; Infante, Sosa-Rubi &Cuadra, 2009). Adequate access to health care and provision of hormone therapy significantly increases the quality of life of transsexual women, and the availability of trans-specific health education could positively influence their health risk behaviour patterns (Bockting, Robinson, Benner &Scheltema, 2004; Newfield et al., 2006).

In South Africa, Chapter two of the South African Constitution proclaims that health care is a human right for all citizens. It states that each citizen has a right to healthcare services, including reproductive health care (Republic of South Africa, 1997). Furthermore, the National Health Act of 2004 aims to provide the best possible health services to the country. It is written that it protects and promotes the rights of vulnerable groups, including women, children, older persons and the disabled (National Department of Health, 2004). However, transsexual women are not stipulated as a vulnerable group, with the result that they are excluded from focused health programmes.

Literature review revealed limited research that is conducted in Africa on the health issues of the Transsexual and Lesbian, Gay, Bi-sexual and Intersex (LGBTI) community. This could be due to the belief that this phenomenon is un-African. The limited African research on transsexual and LGBTI communities raises a concern with regard to evidence-based health care for these vulnerable communities. This article aims to contribute to this identified gap.

The study was conducted in the Western Cape Province of South Africa. The Western Cape Province has only one public clinic dedicated to assist transsexual women with their sexual realignment. This results in long waiting list for surgery of about 25 years and near inaccessibility for women who reside outside the city as they would need to travel hundreds of kilometres to access this clinic.

This dedicated clinic only assists transsexual women with endocrine and plastic surgery services. The rest of their general health care needs, which are often related to side-effects of the realignment treatment, are referred and managed in the general healthcare system which is also referred to as heteronormative health care in this article.

The research question of this study was: 'What are the lived experiences, and meaning of these experiences, for transsexual women during the sexual realignment process when negotiating health care for their transgender-related healthcare needs in a heteronormative health care system?'

The objective was to describe, analyse and interpret the experiences which transsexual women have in negotiating health care in a heteronormative healthcare system.

Methodology

This study was conducted in the Western Cape Province of South Africa. Ten transsexual women were sampled to take part in this study through purposive and snowball sampling. The sample included both rural and urban women, whose ages ranged between 27 and 70 years. Their racial demographic profile represented the demographics of the province.

In order for a participant to be included in the study, she would have to be older than 18 years of age and had to be on the journey of sexual realignment using feminising hormones, with or without having had surgical sexual realignment. If a woman had displayed suicidal ideation and acted upon it in the three months before the study, she would automatically be excluded.

The researcher provided each possible participant with an information leaflet explaining the study, and written consent to participate in the study was obtained from each participant.

Data were collected through in -depth interviews. On average each interview lasted 80 minutes. The interview sessions were digitally recorded and transcribed

verbatim. The data analysis was guided by the steps set out by Smith (2010) for interpretative phenomenological analysis (IPA) (Smith, 2010). Data collection

and data analysis was a concurrent process, after which a cross-case analysis was done.

Ethical considerations

The ethical principles implemented in this study were guided by aspects of the Declaration of Helsinki (World Medical Association, 2008). The Following issues were addressed:

10. Permission to conduct this study was granted by the University of Cape Town Faculty of Health Sciences Research Ethics Committee
11. Written informed consent was obtained from each participant
12. Participants remained anonymous throughout the study; nom de plumes were assigned to participants to protect their identity.
13. Collected data was stored electronically as password protected files on the researcher's personal computer, and back-up password protected copies were kept in a locked office.

Trustworthiness

In order to have ensured trustworthiness of the research, Guba's (1981) model was applied to this study. The following measures were applied to ensure credibility, comfirmability, dependability and transferability:

24. Thick descriptions in the participants' voice are presented together with the interpretation of the researcher in order to assist the reader with an understanding of the phenomenon, and to be able to make informed critique.
25. The preconceptions of the researcher were acknowledged, and bracketing assisted the researcher to maintain the rigor of the study.
26. Two sampling methods were used.
27. Informal and formal member checking was done with participants.

Results

Data analysis resulted in the emergence of the main theme "*Facing the Giant inOrder to Become*" which was made of the following clusters: Practitioners withpower preventing progress on the realignment journey, Fearing care, and Fearing transphobia.

Practitioners with Power Preventing Progress on the Realignment Journey

Healthcare practitioners are viewed as people who are in a position of power. They have the power to decide when and how transsexual women will receive care in

order to have their physical body realigned. This imbalanced relationship of power between transsexual women and healthcare practitioners is clearly demonstrated by a participant, when she uses the metaphor of the doctor ‘playing

God' when he refuses to provide her with surgery which will assist her with her normal physiological functioning:

"... I am very uncomfortable with him, but I am comfortable with the other doctors. I even told him he is not playing God, he is put there for a reason to... He took that position to do that type of work so he must do that type of work. Don't turn people away, don't be nasty with us! He is very nasty. I told that to him in his face Tuesday. I was there ... Oh God help me. Fuck it. Life is a terrible journey that nobody can explain."

Being informed of exactly what she needs to be able to function, she feels disempowered, and there is not much she can do in order to change this situation.

In overstepping the professional boundaries, healthcare practitioners can even go as far as to project their personal beliefs towards transsexual women:

"... one doctor at Hospital A told me plainly: 'Why aren't you happy with your body? Why can't you be a man? The men in society are already so few, and then you still want to be a woman.' I referred the case to the transgender board and nothing happened about it."

Fearing Care

Doctors are found to be uncomfortable when they treat transsexual women, and they often seem to be more inquisitive than committed to providing a quality health service:

"And in many instances when I have spoken to a doctor out of the endocrine clinic, and [he] looks at my folder and looks at me, he looks confused. It would be uncomfortable. With most I have found that they were professional and with a few, I think it has happened with me once or twice, where they were direct and would ask if you are transsexual [softly]. One was so blunt to ask if you are actually a man."

The following extract from a participant who had an encounter with nurse practitioners following a suicidal attempt depicts the health care practitioners' conduct which inflicts secondary trauma.

"And I was rushed to a day hospital. I went in there, and then.....one of the sisters came over, and hmm, took blood and all that crap. Told me to take my clothes off. I took my clothes off and she came in there and just said Ohhhhhh, and just went out again. She came in with two more sisters. And I was like, ok, it was now ok for you to be alone here to do whatever you needed to do, so what is this now. And I knew it was for the fact that they could see

breasts..... and the bottom part was not what is was supposed to be in their eyes. And I felt embarrassed”.

This unprofessional conduct was further substantiated by another participant when she reports on her admission at a district hospital as follows.

“I couldn’t really hear what was being said. Few nurses came to ask me why I was not moving. What are you (referring to gender)? (They asked). I explained. They looked fearful.

Such encounters with healthcare professionals leave transsexual women to be anxious should they have to engage with the health care system. This fear of what may happen in the health care system can prevent transsexual women from obtaining care should they have health problems.

Fearing transphobia

Transsexual women have a fear of transphobic attacks from healthcare practitioners in the services, they are ill-treated by healthcare professionals merely because they are seen as different and they are of the opinion that their health needs are not seen as a priority.

One participant expressed her fear of transphobic attacks experienced should she ever have to visit a public health care facility as follows:

...Yes, I will really borrow money to go to a private doctor because I am scared of transphobic attacks at the clinic. I am really scared for that...

This fear is not unwarranted. One participant was ignored in a district hospital post-surgery when health care practitioners “discovered” she is transsexual, while another was refused a bed in a tertiary hospital as there are no beds available for transsexual women. This was also identified as transphobic attack on these women.

“The day I went into the theatre, they booked me into the female ward. The next day when I went in for my operation, it wasn’t even half an hour thereafter, then they moved me out to another ward. So I wondered why? Then I heard that they can’t put me in a female ward because I’m not a woman. They put me in a small side-ward and left me there. It’s like someone who has leprosy. The doctor never came to see me; I had very, very little contact with anyone there. I was disappointed, really I was.

The following extract also demonstrates this transphobic attack.

“And they left me at reception until a doctor could come there and he took me to a room where we could be alone, and did what he had to do, and then from there I had to go back to the waiting room and sit there until I could see a

psychiatrist, because there is no wards for trans women.”

A general theme of ignoring transsexual women surfaced, when they are in need of care beyond care for their physical transition. One participant highlighted the absence of care she received in a rural area after her stroke as follows.

"It was very very bad. They just give you your tablets and finish and klaar. I took myself to physiotherapy. I took myself to the gym to get my arm right and my leg right. I did my own speech therapy. Everything on my own. Which is not nice. There is no help for you because you are that 'type of person', you know? It is not nice.

Being constantly ill-treated at health care facilities, transsexual women strongly felt that they are not seen as a priority in the health care system. This was also analysed and interpreted as transphobic attack on the transgender woman and is demonstrated in the following extracts.

"I'm actually angry! I feel that somehow, I am getting the short end of the stick just because I am trans. Or just because I am not so-called normal to what people think normal should be. Because, I mean honestly, when did you decide what should be normal and what's not normal. I mean if I had a choice, this is most definitely not a road that I would have picked for myself".

Another extract demonstrated this as follows:

"It makes me feel you are not important in the eyes of the world, or that people that can help you or have the necessary knowledge, have the necessary facilities to help you, they don't see you as important. They don't see your body as important, and they don't see your emotions as important, so it feels to me I'm just on a list, but I'm just there. So, I'm just a number. It's nothing else but a number. I don't want to feel like a number, because I believe numbers belong on telephones and I feel I am a human being and much more important than a number (in tears)"

These findings highlight the plight of transsexual women as they negotiate for health care during their journey of becoming. The healthcare team is described as the gatekeepers to the freedom of transsexual women, yet they are also seen as giants that can make or break the transsexual woman's journey of becoming.

Discussion

Through interpretation of the lived experiences of transsexual women within the healthcare system, clear signs emerge that they are prevented from fully expressing themselves. The members of the multidisciplinary team contribute to preventing transsexual women from becoming free from their restrictive

embodiment which is incongruent with their inner gender identity.

It would be easy to argue that the population of transsexual women is small and that there are other clients in the healthcare system who are in greater need of care, but if we evaluate the conduct of the multidisciplinary team against the Nurses' Pledge and revisit the Patients' Rights Charter, it becomes clear that health practitioners are indeed failing transsexual women (National Department of Health, 2014; South African Nursing Council, 2014).

The Nurses' Pledge states that the total health of a patient will be the first priority of the healthcare provider. However, transsexual women feel that they are treated as second-class citizens and their healthcare needs are not seen as a priority. If a waiting list of more than 20 years exists for a surgical procedure which could improve the quality of life of a woman, can we say that the total health of the patient is our first priority?

Confidentiality is one of the key basic principles that all healthcare practitioners should adhere to. Often confidentiality is breached when it comes to the transsexual patient, when ignorant healthcare practitioners feel the need to inform other practitioners to come and see the anomaly. Such conduct may lead to secondary victimisation and trauma; particular reference is made to the participant in this study who was traumatised by ignorant, inquisitive healthcare professionals after she attempted suicide.

Healthcare practitioners should not allow religion, nationality, race, social standing, sexual orientation or gender identity to intervene between their duty and their patients. Is it acceptable to ask transsexual women why they are not satisfied with the bodies they were born into?

If healthcare practitioners pledge themselves to the service of humanity, they should critically reflect on their conduct with all patients who present to them for care and not become a barrier to care.

Transsexual women have the right to participate in the decision-making on their health care. Ideal practice would entail that health practitioners together with their transsexual client should collaboratively decide on how their journey of sexual realignment should proceed. This would immediately break down the perception that healthcare practitioners hold the power over transsexual individuals.

Access to appropriate health care with health practitioners who are courteous, tolerant and respect the human dignity of transsexual women is another basic right which should be protected. It is thus expected of healthcare practitioners that they be able to create a health environment which affirms transsexual women and their needs.

Health practitioners should also be able to give accurate information to transsexual

women about their health status, their treatment plan and possible

complications to empower them to have more control over their sexual realignment journey.

The health rights of transsexual women are no different to the health rights of other patients; however, healthcare practitioners are often guilty of infringing the rights of transsexual women. This might be due to the fact that health practitioners are never exposed to and trained on the issues of transsexual women during their undergraduate training programmes, and would thus not have the clinical and affective skills and knowledge to provide a quality service to these clients. It is recommended that issues of gender identity and sexuality are included in the training of health professionals, and that current health professionals are sensitised to the health needs of transsexual women through continuous professional development programmes.

Conclusion

The role of the healthcare practitioners within the heteronormative health care system is important to ensure that the transsexual women's journey of becoming is as smooth and uneventful. Our findings show that this remains to be realised by the South African transsexual women. More research and collaborative engagement between the healthcare practitioners and the transsexual women may assist both parties to develop interventions that will benefit both.

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Appendix I Ethics approval

UNIVERSITY OF CAPE TOWN



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22 August 2013

HREC REF: 438/2013

A/Prof S Duma
Health & Rehab
F45, OMB

Dear A/Prof Duma

PROJECT TITLE: TRANSSEXUAL WOMEN ON THE JOURNEY OF SEXUAL RE-ALIGNMENT IN A HETERO-NORMATIVE HEALTH SYSTEM IN THE WESTERN CAPE

Thank you for your letter to the Faculty of Health Sciences Human Research Ethics Committee dated 20th August 2013.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year till the 30th August 2014

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/research/humanethics/forms)

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC. REF in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.
The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

s.thomas